DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 445114 05/08/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5837 LYONS VIEW PIKE BRAKEBILL NURSING HOME INC. KNOXVILLE, TN 37919 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 000 F 000 INITIAL COMMENTS An annual Recertification survey and complaint investigation (#TN-31550, #TN-31385, and #TN-31543) was completed on May 8, 2013, at Brakebill Nursing Home. Deficiencies were cited under 42 CFR Part 483, Requirements for Long Term Care, related to the annual Recertification survey and complaint #TN -31543. F 272 F 272 483.20(b)(1) COMPREHENSIVE F 272 It is the practice of Brakebill Nursing and Rehabilitation SS=D | ASSESSMENTS Center to conduct initially and periodically a comprehensive, accurate, standardized, reproducible The facility must conduct initially and periodically assessment of each resident's functional capacity. a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. Corrective Action: A facility must make a comprehensive assessment of a resident's needs, using the For resident # 77, a comprehensive resident assessment instrument (RAI) specified assessment was completed by MDS by the State. The assessment must include at Coordinator on 5/3/2013 with a significant least the following: change update on 5/9/2013. Identification and demographic information; Customary routine; Cognitive patterns; Identification of other residents having the Communication; notential to be affected: Vision; Mood and behavior patterns: All residents in the facility were identified as Psychosocial well-being; having the potential to be affected by not having Physical functioning and structural problems; a periodically, comprehensive, accurate, standardized, Continence: reproducible assessment. Residents identified on review Disease diagnosis and health conditions; by MDS Coordinator for updated assessments were Dental and nutritional status: completed and are now current. Skin conditions; Activity pursuit: Medications; Measures to be put in place and systemic Special treatments and procedures; changes: Discharge potential: Documentation of summary information regarding (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

|                          |   | AND HUMAN SERVICES  & MEDICAID SERVICES  |                   |            |  | FORM /  | APPROVED<br>0938-0391      |
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|                          | OVIDER OR SUPPLIER  | INC.   |                   | 5837       | ET ADDRESS, CITY, STATE, ZIP CODE<br>7 LYONS VIEW PIKE   | 1 03/1  | 16/2013                    |
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| F 275                    | This REQUIREME by: Based on medical the facility falled to assessment for on residents reviewed The findings include Resident #77 was March 17, 2011, w Failure to Thrive, A Congestive Heart Medical record rev (MDS) revealed th completed on Dec revealed the facility comprehensive as Interview on May MDS office with M confirmed the Ma completed. 483.20(b)(2)(iii) C | SSMENT performed on the care the completion of the Minimum and participation in assessment.  NT is not met as evidenced record review and interview, complete a comprehensive e resident (#77) of sixty-four l.  led: admitted to the facility on ith diagnoses including Adult Alzheimer's Disease, Dementia, Failure, and Atrial Fibrillation.  View of the Minimum Data Set as least assessment was been per 7, 2012. Further review by failed to complete the essessment for March 2013.  1, 2013, at 8:50 a.m., in the AIDS Registered Nurse (RN) #2 rch 2013 MDS had not been as comprehensive ASSESS AT COMPREHENSIVE A |                   | 272        | MDS Coordinator will maintain a moschedule of all residents who are due periodic updates. An additional full to MDS coordinator, previously part-tip been added effective April 23, 2013 assigned to the MDS office to meet the assessment schedules for each reside addition, a contract MDS coordinator previously utilized since March, 2013 also been extended to ensure all indicassessments are completed and are to Progress will be reported on an ongood daily basis in morning admission remeeting.  Monitoring of corrections will be a continued, ongoing program utilizing supervisor and MDS coordinators. Supervisor will verify assessment seand accuracy of the coordinators by observation and chart review in account to MDS requirements and assessments and assessments and accuracy of the coordinators by observation and chart review in account to MDS requirements and assessments and assessments and accuracy of the coordinators by observation and chart review in account to MDS requirements and assessments and accuracy of the coordinators by observation and chart review samples and will also utilize direct observation and chart review samples and decline in ADL's, significant in mental or physical status, the or of an incident, or if hospitalization required to address their conditions and their conditions and chart review to address their conditions and address their condi | their time time me, has and ne nt. In or, 3, has cated imely. bing view  mg MDS mdDS chedules y direct cordance ent of to morning blings. All ton a change ccurrence is |                            |
| 1                        | 483.20(b)(2)(iii) C<br>  LEAST EVERY 1.   |  | ļ F               | - 275<br>! | of an incident, or if hospitalization required to address their condition addition to reporting MDs and car  | n. In   |                            |

|                          |   | AND HUMAN SERVICES  & MEDICAID SERVICES   |                     |   | FORM.                           | APPROVED<br>0938-0391      |
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|                          |   | 445114  | B. WING             |   | 05/                             | 08/2013                    |
| BRAKEB                   | ROVIDER OR SUPPLIER   | INC.  |                     | FREET ADDRESS, CITY, STATE, ZIP CODE<br>5837 LYONS VIEW PIKE<br>KNOXVILLE, TN 37919   |                                 |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)  | LD BE                           | (X5)<br>COMPLETION<br>DATE |
| F 275                    |   | age 2<br>Juct a comprehensive<br>esident not less than once   | F 27                | updates during the morning admission meeting, compliance will also be revisan agenda item monthly as a part of QA/QI process. This process will occan ongoing daily and monthly basis.  | ewed as<br>the                  |                            |
|                          | by: Based on medical the facility failed to assessment within comprehensive as sixty-four residents The findings includ Resident #77 was March 17, 2011, w Failure to Thrive, Congestive Heart Medical record re (MDS) revealed th assessment was review revealed th comprehensive a Interview on May MDS office with N confirmed the fac |   |                     | Brakebill Nursing and Rehabilitation Center ensures that the facility conditions comprehensive assessment of a resident stan once every 12 months.  Corrective Action:  Resident # 77 has received a comprehensive as required.  Assessment completed 5/17/2013 by Coordinator on 5/3/2013.  Resident # 65 has received a comprehensive as required. Assessment completed 5/17/2013 by MDS Coordinator on 5/2/2013. | ducts a dent not ehensive y MDS | 6 zılı                     |
|                          | 3, 2008, with diagonal dementia with de cardiovascular Delmonary Fibro  | s admitted to the facility on July<br>gnoses including Senile<br>elirium, Arteriosclerosis,<br>bisease, Hyperlipidemia,<br>sis, Hypertension, Delusion<br>y, and Convulsions. |                     | Identification of other residents hat potential to be affected:  Record review by MDS coordinated to DON confirmed that only the residentified were affected.   | ator and                        |                            |

PRINTED. VOLTAZUTO DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING \_ 445114 B. WING 05/08/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5837 LYONS VIEW PIKE BRAKEBILL NURSING HOME INC. KNOXVILLE, TN 37919 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION). TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 275 Continued From page 3 F 275 Measures to be put in place and systemic Medical record review of the Minimum Data Set changes: (MDS) revealed the last comprehensive assessment was dated March 22, 2012. Further review revealed the facility failed to complete the MDS Coordinator will maintain a monthly comprehensive assessment for March 2013. schedule of all residents who are due their periodic updates. An additional full time Interview on May 8, 2013, at 1:35 p.m., in the MDS coordinator, previously part-time, has MDS office with MDS RN #1 confirmed the been added effective April 23, 2013 and facility failed to complete the comprehensive assigned to the MDS office to meet the assessment due in March 2013. assessment schedules for each resident. In addition, a contract MDS coordinator, previously utilized since March, 2013, has also been extended to ensure all indicated F 276 483.20(c) QUARTERLY ASSESSMENT AT F 276 assessments are completed and are timely. LEAST EVERY 3 MONTHS SS=D A facility must assess a resident using the quarterly review instrument specified by the State Monitoring of corrective actions: and approved by CMS not less frequently than once every 3 months. Monitoring of corrections will be a continued, ongoing program utilizing MDS This REQUIREMENT is not met as evidenced supervisor and MDS coordinators, MDS Supervisor will verify assessment schedules by: Based on medical record review and interview, and accuracy of the coordinators by direct the facility failed to complete quarterly Minimum observation and chart review in accordance Data Set (MDS) assessments within the required to MDS requirements and assessment three month time frame for two residents (#14. schedule. In addition, the Director of #102) of sixty-four residents reviewed. Nursing and Administrator will also determine compliance during daily morning The findings included: meeting and will also utilize direct observation and chart review samplings. All Resident #14 was admitted to the facility on residents will also be reassessed upon a January 14, 2004, with diagnoses including noted decline in ADL's, significant change Osteoarthritis, Chronic Ischemic Heart Disease, in mental or physical status, the occurrence Full Incontinence, Hypertension, and History of

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Fall.

Event ID: ECUM11

of an incident, or if hospitalization is

beginning 6/1/2013.

required to address their condition. In addition to review during the daily morning admission meeting, compliance will also be

reviewed monthly as an ongoing monthly agenda item as a part of the QA/QI process sheel Page 4 of 8

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING B. WING 445114 05/08/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5837 LYONS VIEW PIKE BRAKEBILL NURSING HOME INC. KNOXVILLE, TN 37919 SUMMARY STATEMENT OF DEFICIENCIES Œ PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 276 6/21/13 F 276 | Continued From page 4 F 276 Brakebill Nursing and Rehabilitation Medical record review of the resident's MDS Center will ensure that the facility will revealed, the last quarterly MDS assessment was access a resident using the quarterly review completed on December 10, 2012, and the next instrument specified by the State and quarterly MDS assessment was due on March approved by CMS not less frequently than 10, 2013. once every 3 months. Interview with the MDS coordinator #2, on May 1, 2013, at 11:10 a.m., in the MDS office, confirmed Corrective action that will be accomplished the March quarterly MDS assessment had not been completed until April 25, 2013. for those residents found to have been affected: Resident #102 was admitted to the facility on April 6, 2012, with diagnoses including Congestive Resident #14: No opportunity to retro Heart Failure, Hypertension, Diabetes Mellitus correct assessment date as resident received Type 2, Dementia, Psychotic Disorder, and a quarterly MDS assessment on April 25, Depression. 2013. Medical record review of the resident's last Resident # 102: No opportunity to retro quarterly MDS assessment was completed on correct assessment date as resident received January 7, 2013, and the next quarterly MDS a quarterly MDS assessment on May 10, assessment was due on April 7, 2013, 2013. Interview with the MDS Coordinator #1 on May 7, Identification of other residents having the 2013, at 1:17 p.m., in the MDS office, confirmed potential to be affected: the quarterly MDS had not been completed timely as required, All residents in the facility were identified as F 278 483.20(g) - (j) ASSESSMENT F 278 having the potential to be affected by not having ACCURACY/COORDINATION/CERTIFIED SS≒D a periodically, comprchensive, accurate, standardized, reproducible assessment. Residents identified on review The assessment must accurately reflect the by MDS Coordinator for updated assessments were resident's status. completed by May 31, 2013 and are now current. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. Measures to be put in place and systemic changes: A registered nurse must sign and certify that the

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assessment is completed.

Event ID: ECUM11

MDS Coordinator will maintain a monthly schedule of all residents who are due their periodic updates. An additional full time MDS coordinator, previously part-time, has been added effective April 23, 2013 and assigned to the MDS office to meet the assessment schedules for each resident. In addition, a contract MDS coordinator,

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING \_ 445114 B. WING 05/08/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5837 LYONS VIEW PIKE BRAKEBILL NURSING HOME INC. KNOXVILLE, TN 37919 (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION מו (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) previously utilized since March, 2013, has F 278 | Continued From page 5 F 278 also been extended to ensure all indicated assessments are completed and are timely. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Monitoring of corrective actions: Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and Monitoring of corrections will be a false statement in a resident assessment is continued, ongoing program utilizing MDS subject to a civil money penalty of not more than supervisor and MDS coordinators. MDS \$1,000 for each assessment; or an individual who Supervisor will verify assessment schedules willfully and knowingly causes another individual and accuracy of the coordinators by direct to certify a material and false statement in a observation and chart review in accordance resident assessment is subject to a civil money to MDS requirements and assessment penalty of not more than \$5,000 for each schedule. In addition, the Director of assessment. Nursing and Administrator will also determine compliance during daily morning Clinical disagreement does not constitute a meeting and will also utilize direct material and false statement. observation and chart review samplings. All residents will also be reassessed upon a noted decline in ADL's, significant change This REQUIREMENT is not met as evidenced in mental or physical status, the occurrence Based on medical record review and interview, of an incident, or if hospitalization is the facility failed to assure each resident receives required to address their condition. In an accurate assessment by staff who are addition to review during the morning qualified to assess relevant care areas and admission meeting, compliance will also be knowledgeable about the resident's status, reviewed as an ongoing agenda item needs, strengths, and areas of decline for three monthly as a part of the QA/QI process. residents (#72, #210, and #123) of sixty four residents reviewed. F 278 The findings included: Resident #72 was admitted to the facility on Brakebill Nursing and Rehabilitation December 10, 2012, with diagnoses including Center believes that the assessment must Advanced Alzheimer's Dementia, Osteoarthritis, accurately reflect the resident's status. Dysphagia, and Pneumonia. Corrective action that will be accomplished

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affected:

Resident # 72 as identified in the summary

was reassessed by licensed nurse and the

for those residents found to have been

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|  |   | ANU HUMAN SERVICES  & MEDICAID SERVICES  |                     |  | FORM.   | US/14/ZUT3<br>APPROVED        |
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| TATEMENT OF DEFICIENCY PLAN OF CORRECT   | NCIES   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                     | PLE CONSTRUCTION<br>IG   | (X3) DATE   | 0938-0391<br>SURVEY<br>PLETED |
| ·  | ~~  | 445114   | B. WING             |  | 050   | 08/2013                       |
| NAME OF PROVIDER O   | R SUPPLIER  |  | s                   | TREET ADDRESS, CITY, STATE, ZIP COD  |   | 10/20 13                      |
| BRAKEBILL NURS   | ING HOME  | INC.   |                     | 5837 LYONS VIEW PIKE<br>KNOXVILLE, TN 37919  | _   |                               |
| PREFIX (EAC  | H DEFICIENC'  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR   | SHOULD BE   | (X5)<br>COMPLETION<br>DATE    |
| Medical Data Se "Loss 10% or 1 Yes, on regiment Medical Assessr "Wt. (v Body W puree Medical form rev in Dece 2013. (1 Intervier Registe confirm prescrib coded i Reside Novem Abnorm and De Medical Minimus 2012, r Restor Medical Outpat | t (MDS) da of 5% or m more in las physician-r"  record revi ment dated weight) (lb. eight)/ usus Overall Ris record rev vealed the r mber, 2012 1.46% wei haccurately and #123 wa ber 15, 20 hality of Ga mentia with I record rev evealed the ative Nursi al record rev ient Rehab | ew of the quarterly Minimum ted March 9, 2013, revealed, ore in the last month or loss of the Months(coded as a 1) prescribed weight-loss few of the Nutrition Risk December 17, 2012, revealed, pounds) 157IBW (Ideal al 90-110Diet order to Category: High" few of the appetite/supplement resident weighed 157 pounds 2, and 138.9 pounds in March, ght loss in 3 months) for 2013, at 8:20 a.m., with MDS #1, in the training room, dent was not on a physician floss regimen and the MDS was was with diagnoses including lit, Generalized Pain, Aphasia, in Behavioral Disturbance. Wiew of a Significant Change at (MDS) dated December 26, a resident had not received ang Services. |                     | MDS was corrected and coded MDS Coordinator on 4/24/201 Resident # 123 was reassessed nurse and the MDS was correacted by the resident by M Coordinator 4/19; 4/30 and 5/4 Resident # 210: MDS assessment corrected by MDS coordinator resident's accurate weights. I weight loss was reviewed by the team and necessary recommendate interventions were initiated of the potential to be affected:  Record review by MDS coordinator residents identification of other reside potential to be affected:  Record review by MDS coordinator residents identified were affected:  Measures to be put in place changes:  Education and training will staff upon orientation and s reinforcement as standard pongoing staff training and it Monitoring of corrective accurate was accurated as a standard pongoing staff training and it Monitoring of corrective accurate was accurated as a standard pongoing staff training and it monitoring of corrective accurate was accurated as a standard pongoing staff training and it monitoring of corrective accurate was accurated as a standard pongoing staff training and it monitoring of corrective accurate was accurated as a standard pongoing staff training and it monitoring of corrective accurate was accurated as a standard pongoing staff training and it monitoring of corrective accurate was accurated as a standard pongoing staff training and it monitoring of corrective accurated as a standard pongoing staff training and it monitoring of corrective accurated as a standard pongoing staff training and it monitoring of corrective accurated as a standard pongoing staff training and it monitoring of corrective accurated as a standard pongoing staff training and it monitoring accurated as a standard pongoing staff training and it monitoring accurated as a standard pongoing staff training and it monitoring accurated as a standard pongoing accurated as a standard pongoing staff training and it monitoring accurated as a standard pongoing accurated as a standard pongoing accurated as a standard pongoing accurated as a standar | d correctly by 13.  by licensed acted to for the services and acted to for reflect the Residents' weight loss and an 5/29/2013.  Into having the acted.  and systemic be used for new cheduled for protocol during in-services. |                               |
| "Pt ( <br>FORM CMS-2567(02-99)   | patient) d/c  | d (discharged) from PT   |                     | Monitoring of corrections a continued, ongoing program supervisors and direct obse   | n utilizing shift   | Anni Dana - 77 - 17           |

| DEPART                   | MENT OF HEALTH  | AND HUMAN SERVICES  & MEDICAID SERVICES  |                   |     | C  | , 4  | APPROVED 0938-0391         |
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|                          | ROVIDER OR SUPPLIER<br>ILL. NURSING HOME  | INC.   |                   |     | TREET ADDRESS, CITY, STATE, ZIP CODE<br>5837 LYONS VIEW PIKE<br>KNOXVILLE, TN 37919  |  |                            |
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| F 278                    | (physical therapy) (Restorative Nursir (ambulate) pt as to Medical record rev Physical Therapy (dated and signed I "RNA to Amb pt Interview with MDS May 8, 2013, at 10 confirmed the Decaccurately reflect treceived by the re Resident #210 wa January 22, 2013, Anemia, Hyperter Cerebrovascular // Medical record re MDS assessmen was incorrect. The pounds (lbs.), and pounds.  Review of the fact resident's admissions at 146 lbs.; Fel March 19, 2013, was 126 lbs.  Interview with MI 2013, at 10:45 at the weight record the sixty day MD 2013, was incorrect. | services on 12/17/12RNA ng Assistant) to amb plerated" lew of Occupational and Orders and Treatment Record, December 18, 2012, revealed, as tol (as tolerarted)" S Registered Nurse (RN) #2 on 0:48 a.m., in the MDS Office, cember 26, 2012, MDS did not the status of the services | 3, 3              | 278 | shifts. MDS Coordinators will also we accuracy and usage by direct observer and chart review in accordance to M requirements and assessment schedule addition, the Director of Nursing and Administrator will also determine compliance utilizing direct observation chart review samplings. All resident also be reassessed upon a noted decly ADL's, significant change in mental physical status, the occurrence of an incident, or if hospitalization is required address their condition. In addition morning admission meeting, MDS assessments and schedules will be remonthly beginning June 1, 2013 as continuing agenda item as a part of QA/QI process. | erify ation IDS Ile. In d ion and s will ine in or tired to to the |                            |

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|   |  | 445114  | B. WING           | ;   |  | 05/   | 08/2013                         |
|   | ROVIDER OR SUPPLIER<br>ILL NURSING HOME  | INC.  |                   | 583 | ET ADDRESS, CITY, STATE, ZIP CODE<br>87 LYONS VIEW PIKE<br>IOXVILLE, TN 37919  | <u> </u>  | 06/2013                         |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG | ix  | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOIL<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY)   | JLD BE  | (X5)<br>COMPLETION<br>DATE      |
| F 278   | Continued From pa<br>resulting in the MD<br>6 percent weight lo  | S assessment not triggering a   | F                 | 278 | F 279  |   | 6/21/13                         |
| F 279<br>SS=E   | 483.20(d), 483.20(l<br>COMPREHENSIVI<br>A facility must use<br>to develop, review<br>comprehensive pla | E CARE PLANS  the results of the assessment and revise the resident's   | F                 | 279 | Brakebill Nursing and Rehabilitz<br>Centers goal is to ensure that the<br>from residents assessment is used<br>develop, review and revise the re<br>comprehensive plan of care.  | results<br>to   |                                 |
|   | plan for each resid<br>objectives and time<br>medical, nursing, a                                      | evelop a comprehensive care ent that includes measurable etables to meet a resident's and mental and psychosocial ntified in the comprehensive  |                   |     | Corrective action that will be acc<br>for those residents found to have<br>affected:  Resident #156: Residents care pl   | been  | 1                               |
| to be furnished<br>highest practic<br>psychosocial w<br>§483.25; and a<br>be required un<br>due to the resi |  | st describe the services that are attain or maintain the resident's physical, mental, and being as required under services that would otherwise §483.25 but are not provided t's exercise of rights under the right to refuse treatment 4). |                   |     | developed by MDS Coordinator an indwelling catheter including and maintenance. Resident has s discharged to a private pay facil were on a wait list.  Resident # 106: Residents care p by MDS Coordinator on 5/21/20 and address the resident's use of | catheter ca<br>ince<br>ity where the<br>lan updated<br>13 to reflec<br>'routine | ra<br>Ie:                       |
|   | by: Based on medica and interview the comprehensive ca (#156, #106, #186                               | ENT is not met as evidenced al record review, observation, facility failed to develop a are plan for eight residents 0, #267,#72, #41, #78, and r residents reviewed.   |                   |     | and PRN pain medication for pamanagement.  Resident # 267: No opportunity or correct as resident expired dimedical conditions and diagnosi Resident # 72: Resident's care p by MDS Coordinator on 5/22/20 pain management goals and into               | to address<br>le to<br>s.<br>Ian updated<br>13 to reflec                        |                                 |

|                          |   | AND HUMAN SERVICES  & MEDICAID SERVICES  |                     |  | FORM APPROVED  |  |  |
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| TATEMENT                 | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                     | LE CONSTRUCTION  | OMB NO. 0938-0391<br>(X3) DATE SURVEY<br>COMPLETED   |  |  |
| NAME OF P                | ROVIDER OR SUPPLIER   | 445114   | B. WING             |  |  |  |  |
|                          | ILL NURSING HOME  | INC.   |                     | REET ADDRESS, CITY, STATE, ZIP CODE<br>5837 LYONS VIEW PIKE<br>KNOXVILLE, TN 37919   |  |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES OF THE | D BE COMPLETION  |  |  |
| F 279                    | November 5, 2012 Dementiawith Be Rheumatoid Arthrit Artery Disease with seizures, recent on Disease, Osteopor Irritable Bowel Syn Review of the quar dated February 8, had an indwelling of Review of the Order Physician's Orders revealed, "Foley wound heals" C Progress Note dat revealed, "Pt (pa will place foley to be Observation on Ap the resident's roor indwelling cathete covered with a pri Interview with the 2013, at 8:00 a.m the care plan had of an indwelling ca and maintenance Resident #106 wa with diagnoses in Hypothyroidism, ( | ed:  admitted to the facility on with diagnoses including havioral Disturbances, is, Diabetes Mellitus, Coronary stent, Epilepsy (history of iset) Gastroesophageal Reflux osis, Hypertension, and drome.  terly minimum data set (MDS) 2013, revealed the resident eatheter.  ers and Progress Notes, adated December 12, 2012, catheter with routine care until ontinued review of the ed December 12, 2012, atient) with sacral wounds so nelp with healing"  oril 29, 2013, at 10:15 a.m., in m, revealed the resident had an r in place to bedside drainage vacy bag.  MDS Coordinator #2 on May 2,, in the MDS office confirmed not been developed for the use atheter including catheter care |                     | Resident # 41: A comprehensive can was developed by weight team, diet MDS Coordinator on 4/24/2013 for nutrition and to address weight loss Resident has since elected to relocal state to be closer to family.  Resident # 78: A care plan was dev MDS Coordinator on 6/4/2013 to provide plan of care for the resident comfort measures only status.  Resident # 123: Residents plan of call updated by MDS Coordinator on 4/2 to address and reflect the use of a large resident # 180: Residents care plan been developed by MDS Coordinate 5/1/2013 for the use of an indwelling catheter including catheter care and maintenance.  Identification of other residents has potential to be affected:  Record review by MDS coordinator DON confirmed that only the residing dentified were affected.  Measures to be put in place and sy changes:  MDS Coordinator will maintain a schedule of all residents who are deperiodic updates. An additional furance and additional for MDS coordinator, previously part been added effective April 23, 201  | s. te out of  reloped by rovide a ss  are was /12/2013 ap belt.  In had for on g d  ving the  restemic  monthly lue their all time t-time, has |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES FENINTED. 00114/2010 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 445114 B. WING 05/08/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5837 LYONS VIEW PIKE BRAKEBILL NURSING HOME INC. KNOXVILLE, TN 37919 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) assigned to the MDS office to meet the F 279 Continued From page 10 F 279 assessment schedules for each resident. In Osteoporosis. addition, a contract MDS coordinator, previously utilized since March, 2013, has Medical record review of the annual minimum also been extended to ensure all indicated data set (MDS) dated March 10, 2013, revealed assessments are completed and are timely. the resident scored three out of fifteen on the Unit managers will periodically review Brief Interview for Mental Status indicating severe residents plan of care for accuracy and will cognitive impairment. Continued review revealed update the plan of care upon a noted decline the resident was dependent with one person in ADL's, significant change in mental or assist for bed mobility, transfers, dressing, physical status, the occurrence of an personal hygiene, and bathing. Continued review incident, or if hospitalization is required to revealed the resident was on a scheduled pain address their condition. The Director of medication regimen and received PRN (as Nursing and/or designee will report to the needed) pain medication or was offered and MDS coordinator any changes indicated in declined during the assessment period. the resident's plan of care for appropriate Continued review revealed the resident described updates. the pain as "moderate." Medical record review of the nurse's note dated April 20, 2013, stated the resident was "...crying out in pain. Gave PRN (as needed) Norco (pain Monitoring of corrective actions: medication) as ordered with good effect noted..." Monitoring of corrections will be a continued, ongoing program utilizing shift Review of the Physician's Order dated June 8, supervisors and direct observations when 2012, revealed, "Pain assessment q conducting rounds on their designated (every)shift...document pain rate scale 0-10. shifts. MDS Coordinators will also verify intervention and effect of intervention on PRN accuracy and usage by direct observation sheet..." and chart review in accordance to MDS Review of the Medication Record for May 2013, requirements and assessment schedule. In addition, the Director of Nursing and revealed the resident received routine pain Administrator will also determine medication daily. Continued review revealed physician orders for pain medication Norco compliance utilizing direct observation and

FORM CMS-2567(02-99) Previous Versions Obsolete

q 4 hours for pain.

7.5/325 mg (milligrams) 1/2 tab orai every AM (morning); and Norco 1/2 tab oral PRN (evening)

Review of the Medication Record dated May

2013, revealed the resident's pain had been

Event ID: ECUM11

assessments and schedules will be reviewed in continuation sheet Page 11 of 5

chart review samplings. All residents will

also be reassessed upon a noted decline in

incident, or if hospitalization is required to:

address their condition. In addition to the morning admission meeting, MDS

ADL's, significant change in mental or physical status, the occurrence of an

cend Cere plans will be inpolated permission given by Clabor on 6/10/13 il 10/10/10/10 to cecled information

|                          |  | AND HUMAN SERVICES  & MEDICAID SERVICES  |                     |     |  | FORM /          | 0938-0391                  |
|--------------------------|--|--|---------------------|-----|--|-----------------|----------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     |     | CONSTRUCTION   | (X3) DATE       | SURVEY<br>PLETED           |
|                          |  | 445114   | B. WING_            |     |  | 05"             | 2012042                    |
|                          | ROVIDER OR SUPPLIER  | INC.   |                     | 5B3 | ET ADDRESS, CITY, STATE, ZIP CODE<br>37 LYONS VIEW PIKE<br>IOXVILLE, TN 37919  | <u> </u>        | 08/2013                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | <   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES OF THE | D BE            | (X5)<br>COMPLETION<br>DATE |
| F 279                    | Observation and in April 29, 2013, at 1 room revealed the left rail to relieve pr stated "my bottor Interview with MDS office on May 1, 20 resident's care plan not address the resident #180 was March 25, 2013, (f. hospitalization) with Chronic Obstructive Depression, Recurand Urinary Reten Medical record revealed the residistry and Urinary Reten Medical record revealed the residistry and the continent" of both Medical record revealed no plan of indwelling urinary related to care an catheter had beer Observation and | terview with the resident on 0:37 a.m., in the resident's resident rolled self toward the resident rolled self toward the ressure on the buttocks, and in is getting sore"  6 Coordinator #2 in the MDS 13, at 8:00 a.m., confirmed the reduced March 30, 2013, did sident's use of routine and on for pain management.  6 re-admitted to the facility on collowing an acute h diagnoses including Severe in the Pulmonary Disease, rent Urinary Tract Infections from the resident's Minimum ent, dated January 26, 2013, and was alert with mild cognitive red extensive staff assistance hygiene, was ambulatory by the resident was "always well and bladder.  View of the resident's are plan dated April 2013, of care for the use of an catheter, and no interventions distinct the resident's are plan dated April 2013, of care for the use of an catheter, and no interventions distinct the resident of the indwelling the resident of |                     | 79  | as an agenda item monthly as a part QA/QI process.  Deginning June 1.  permission given be on 6/10/13 11:10 pm  acld above clare.  M   | , 2013<br>1 adm | PHNC-E                     |

| CENTE                    | RS FOR MEDICARE  | & MEDICAID SERVICES  |                   |     |  |                  | FORM   | 05/14/2013<br>APPROVED     |  |
|--------------------------|--|--|-------------------|-----|--|------------------|--|----------------------------|--|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                   |     | PLE CONSTRUCTION                                     | <u>O</u> :       | OMB NO. 0938-0391<br>(X3) DATE SURVEY<br>COMPLETED |                            |  |
| - <u>-</u>               |  | 445114   | B. WING           | G_  | -  |                  |  |                            |  |
| NAME OF P                | ROVIDER OR SUPPLIER  |  | ·                 | ST  | REET ADDRESS, CITY, STAT                             | E ZIR CODE       | 05/0   | 08/2013                    |  |
| BRAKEB                   | ILL NURSING HOME   |  |                   |     | 5837 LYONS VIEW PIKE<br>KNOXVILLE, TN 37919          |                  |  |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAC | FIX | PROVIDER'S PL,<br>(EACH CORRECTIV<br>CROSS-REFERENCE | AN OF CORRECTION | DC   | (X5)<br>COMPLETION<br>DATE |  |
| F 279                    | alert and sitting in a resident stated the toplaced during hospi with a urinary speciato intermittent urinar Interview with LPN a.m., at the 100 hall the resident had an the care plan had not the device and/or it Interview with the ac May 6, 2013, in the facility failed to revisinclude a urinary cato the facility March Resident #267 was 10, 2013, with diagr Mellitus Type II, Con Hypertension, and I Observations reveal indwelling urinary candwelling urinary candw | wheelchair in own room. The urinary catheter had been talization and an appointment alist was pending in May, due ry retention.  #6 on April 30, 2013, at 10:30 nurse's station, confirmed indwelling foley catheter, and ot been updated to address scare.  cting Director of Nursing on training room, confirmed the se the resident care plan to theter present on readmission 25, 2013.  admitted to the facility on April noses including Diabetes ngestive Heart Failure, Dementia.  alied the resident had an atheter on the following dates: 0:52 a.m., April 30, 2013, at 013, while in bed; and May 1, May 7, 2013, at 3:40 p.m., t 8:35 a.m., while in a wheel ew of the nursing note dated ealed "foley catheter attached the work the interim care plan 3, revealed the foley catheter essed. |                   | 279 |  |                  |  |                            |  |
| ORM CMS-2                | 2567(02-99) Previous Versions  | s Obsolete Event ID: ECUN  | 111               |     | Facility ID: TN4702                                  | If continua      | tion shee  | it Page 13 of 5            |  |

SERVICES

|   |   |  |   |  | FORM  | APPROVED<br>0938-0391             |  |
|---|---|--|---|--|---|-----------------------------------|--|
| OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |  |   |  | (X3) DATE SURVEY<br>COMPLETED   |                                   |  |
|   | 445114  | B. WING  |   |  | 05/   | 08/2013                           |  |
|   | INC.  |  | 58  | B37 LYONS VIEW PIKE  |   |                                   |  |
| (EACH DEFICIENC)  | Y MUST BE PRECEDED BY FULL  |  |   | (EACH CORRECTIVE ACTION SHO  | OULD BE   | (X5)<br>COMPLETION<br>DATE        |  |
| Continued From pa   | age 13  | F:   | 279   |  |   |                                   |  |
| room, with the Ass confirmed the facili catheter on the car Resident #72 was December 10, 201 Advanced Alzheim Dysphagia, and Proposition of through April 30, 2 Sulfate (pain medisubcutaneous at thours may repeat (as needed)"  Medical record revision may repeat (as needed)"  Medical record revision on More through April 30, 2 Sulfate (pain medisubcutaneous at thours may repeat (as needed)"  Medical record revision on More than the resident so poservation on More than the resident's revealed the resident the resident so post fall, Demen Thrombosis, and | Istant Director of Nursing, ity had not addressed the re plan dated April 11, 2013.  admitted to the facility on 2, with diagnoses including ter's Dementia, Osteoarthritis, neumonia.  View of the Physician's ders dated April 1, 2013, 2013, revealed "Morphine ication) 4 mg (milligrams) bedtimeMorphine 4mg every 2 (times one) subcutaneous proview of the care plan dated 12, revealed no documentation ent with goals and interventions and interventions flay 1, 2013, at 3:15 p.m., dent was seated in a broda chair doom.  1, 2013, at 10:55 a.m., in the the the acting Director of Nursing I the care plan had not been the care plan had not been fude pain management.  Its admitted November 7, 2012, of Subdural Hematoma status tia, Depression, Deep Vein di Hypertension.  | Г<br> <br> <br> <br> <br> <br> <br> <br> <br>  |   |  |   |                                   |  |
| Medical record r  | eview of the resident's care pla  | n  |   |  |   |                                   |  |
|   | S FOR MEDICARE OF DEFICIENCIES FORRECTION  ROVIDER OR SUPPLIER LL NURSING HOME SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE  Continued From particulation on the car Resident #72 was December 10, 201 Advanced Alzheim Dysphagia, and Pr  Medical record reverse (as needed)"  Medical record reverse (as needed)" | CORRECTION IDENTIFICATION NUMBER:  445114  ROVIDER OR SUPPLIER  LL NURSING HOME INC.  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 13  Interview on May 8, 2013, at 9:45 a.m., in training room, with the Assistant Director of Nursing, confirmed the facility had not addressed the catheter on the care plan dated April 11, 2013.  Resident #72 was admitted to the facility on December 10, 2012, with diagnoses including Advanced Alzheimer's Dementia, Osteoarthritis, Dysphagia, and Pneumonia.  Medical record review of the Physician's Recapitulation Orders dated April 1, 2013, through April 30, 2013, revealed "Morphine Sulfate (pain medication) 4 mg (milligrams) subcutaneous at bedtimeMorphine 4mg every 2 hours may repeat (times one) subcutaneous prn (as needed)"  Medical record review of the care plan dated December 11, 2012, revealed no documentation of pain management with goats and interventions Observation on May 1, 2013, at 3:15 p.m., revealed the resident was seated in a broda chai in the resident's room.  Interview on May 1, 2013, at 10:55 a.m., in the training room, with the acting Director of Nursing (DON) confirmed the care plan had not been developed to include pain management.  Resident #41 was admitted November 7, 2012, with diagnoses of Subdural Hematoma status post fall, Dementia, Depression, Deep Vein Thrombosis, and Hypertension. | S FOR MEDICARE & MEDICAID SERVICES  OF DEFICIENCIES  OF DEFICIENCIES  OF DEFICIENCIES  OF DEFICIENCIES  OF DEFICIENCIES  (X1) PROVIDER SUPPLIER  445114  B. WING  ROVIDER OR SUPPLIER  LL NURSING HOME INC.  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 13  Interview on May 8, 2013, at 9:45 a.m., in training room, with the Assistant Director of Nursing, confirmed the facility had not addressed the catheter on the care plan dated April 11, 2013.  Resident #72 was admitted to the facility on December 10, 2012, with diagnoses including Advanced Alzheimer's Dementia, Osteoarthritis, Dysphagia, and Pneumonia.  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SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 13  F 279  Interview on May 8, 2013, at 9:45 a.m., in training room, with the Assistant Director of Nursing, confirmed the facility had not addressed the catheter on the care plan dated April 11, 2013.  Resident #72 was admitted to the facility on December 10, 2012, with diagnoses including Advanced Alzhelmer's Dementia, Osteoarthritis, Dysphagia, and Pneumonia.  Medical record review of the Physician's Recapitulation Orders dated April 1, 2013, through April 30, 2013, revealed "Morphine Sulfate (pain medication) 4 mg (milligrams) subcutaneous at bedtimeMorphine 4mg every 2 hours may repeat (times one) subcutaneous prin (as needed)"  Medical record review of the care plan dated December 11, 2012, revealed no documentation of pain management with goats and interventions.  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|                          |  | AND HUMAN SERVICES  & MEDICAID SERVICES   |                   |     |  | FORM   | APPROVED                   |  |
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|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                   |     | CONSTRUCTION   | OMB NO. 0938-0391<br>(X3) DATE SURVEY<br>COMPLETED |                            |  |
|                          |  | 445114  | B. WING           | 3   |  | 0.5  | מ אחבוסתו                  |  |
|                          | ROVIDER OR SUPPLIER<br>ILL NURSING HOME  | INC.  |                   | 58: | ET ADDRESS, CITY, STATE, ZIP CODE 37 LYONS VIEW PIKE   | 1 05   | /08/2013                   |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAC | ıx  | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE  | (X5)<br>COMPLETION<br>DATE |  |
| F 279                    | Interview with the a Nursing on May 7, training room, confulant for nutrition has resident had expersors.  Resident #78 was 22, 2012 with diagram Epilepsy, Depressi Psychosis.  Medical record revidated and signed in the many of the resident's conful many in the resident's con | acting Assistant Director of 2013, at 2:45 p.m., in the firmed no comprehensive care ad been developed, and the ienced a significant weight admitted to the facility on June noses including Dementia, ion, Dysphagia, and Affective riew of a physician's order November 28, 2012, revealed, t) CMO (comfort measures t resuscitate)no labs or IV's py), no Xry (X-rays), PO (ora!) view of the resident's care plan i 29, 2013, revealed, ives: DNR" Continued review are plan revealed, Follow advanced directives per s Orders for Scope of |                   | 279 |  |  |                            |  |
|                          | (urinalysis), no IV Interview with the   | bs, no x-rays, no UA 's" acting Director of Nursing 2013, at 9:08 a.m., in the  |                   |     |  |  |                            |  |

| CENTER                   | S FOR MEDICARE  | & MEDICAID SERVICES   |                   |      |  |  | PPROVED                    |
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| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                   |      | E CONSTRUCTION   | OMB NO. 0938-0391<br>(X3) DATE SURVEY<br>COMPLETED |                            |
|                          |   | 445114  | B. WING           | i    |  | 05/09  | 1/2013                     |
|                          | ROVIDER OR SUPPLIER   | · · · · · · · · · · · · · · · · · · ·   |                   | STRE | EET ADDRESS, CITY, STAT'E, ZIP CODE  | _1 03/08   | 12013                      |
| BRAKEBI                  | LL NURSING HOME   | INC.  |                   |      | 37 LYONS VIEW PIKE<br>NOXVILLE, TN 37919   |  | ļ                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG | ıx   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDERICIENCY)           | nee la   | (X5)<br>COMPLETION<br>DATE |
|                          | develop a written ple comfort measures of the resident #123 was November 15, 2012 Abnormality of Gait and Dementia with Medical record revided the use of Medical record reviewaled April 1 at risk for falls second (history) of 5 recent balance and poor seview of the reside interventions to present yalarm) to low (wheelchair)w/c vertically further review of the revealed no care prestraint.  Interview with the answer self-release tap be | amed the facility failed to an of care for the resident's only status.  admitted to the facility on 2, with diagnoses including Generalized Pain, Aphasia, Behavioral Disturbance.  ew of the Quarterly Minimum ted February 20, 2013, a physical restraint.  ew of Pre-Restraining ted April 2, 2013, revealed, withself-release belt"  ew of the resident's care plan, 2, 2013, revealed, "Resident ondary to d/t (due to) hx trails, unsteady gait and safety awareness" Continued ent's care plan revealed event falls "psa (personal v bed et (and) w/c with self-release lap belt"  ne resident's care plan lan for the use of the lap belt enting DON on May 8, 2013, at raining Room, confirmed the lit was a physical restraint, and |                   | 279  | F 280  Brakebill Nursing and Rehabilitate Center believes the resident has the right, unless adjudged incompeter | tion<br>1e<br>nt or                                | 6/21/13                    |
| F 280<br>SS≍E            | the use of a physic 483.20(d)(3), 483.  | plan had not been initiated for   | F                 | 280  | otherwise found to be incapacitate<br>under the laws of the State, to  | e(l  |                            |

|                          |  | AND HUMAN SERVICES   |                     | F   |   | 05/14/2013<br>APPROVED     |
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|                          |  | & MEDICAID SERVICES  | ,                   |   |   | 0938-0391                  |
|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | IPLE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED                                   |                            |
|                          | <del></del> -  | 445114   | B. WING _           |   | 05/0  | 08/2013                    |
| NAME OF P                | ROVIDER OR SUPPLIER  |  | 5                   | STREET ADDRESS, CITY, STATE, ZIP CODE   | 1 00.0  |                            |
| BRAKEE                   | BILL NURSING HOME  | INC.   |                     | 5837 LYONS VIEW PIKE<br>KNOXVILLE, TN 37919   |   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                          | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION   | D BE  | (X5)<br>COMPLETION<br>DATE |
| F 280                    | The resident has the incompetent or other incapacitated under participate in plann changes in care and A comprehensive assinterdisciplinary teal physician, a register for the resident, and disciplines as deter and, to the extent purchase the resident, the relegal representative | e right, unless adjudged<br>erwise found to be<br>r the laws of the State, to<br>ing care and treatment or | F 28                | Resident # 123: The residents care updated by MDS Coordinator on 5 to reflect the resident's most recent resident was reviewed by IDT mem additional interventions as indicate.  Resident # 115: No opportunity to cresidents previous care plan. Residently plan was updated on April 25, 2013.  Coordinator to reflect weight loss interventions.  Resident # 210: Residents care plan been updated by MDS Coordinator 4/23/2013to reflect weight loss interventions. | plan was /16/2013 fall and bers for d. correct ents care by MDS |                            |
|                          | by: Based on medical and interviews, the revise resident car current status, trea four residents (#7 sixty-four residents The findings included Resident #123 was November 15, 201 Abnormality of Ga   |  |                     | Resident # 77: Residents care plan reviewed by weight loss team meml consisting of DON, ADON, RNA, Mecords Coordinator, RD, and MD Assistant and updated by MDS Coon 5/3/2013 to reflect weight loss interventions.  Identification of other residents ha potential to be affected:  An MDS audit by Director of Nurs MDS Coordinator(s) revealed no o residents as being affected.  Measures to be put in place and sy changes:  | bers Medical OS ordinator ving the ing and ther                 |                            |

PRINTED: 05/14/2013

| DEPARTMENT OF HEALTH<br>CENTERS FOR MEDICARE   |   |               |   | KINTED: 05/14/2013<br>FORM APPROVED<br>MB NO. 0938-0391                           |
|--|---|---------------|---|---|
|  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |               | LE CONSTRUCTION   | (X3) DATE SURVEY COMPLETED  |
|  | 445114  | B. WING       |   | 05/08/2013  |
| NAME OF PROVIDER OR SUPPLIER  BRAKEBILL NURSING HOME  (X4) ID SUMMARY STA  | INC.  |               | REET ADDRESS, CITY, STATE, ZIP CODE<br>5837 LYONS VIEW PIKE<br>KNOXVILLE, TN 37919<br>PROVIDER'S PLAN OF CORRECTIO  |   |
| PREFIX (EACH DEFICIENCY  | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG | (EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)   | BE COMPLETION   |
| Data Set (MDS) darevealed the reside impaired and requiral activities of daily  Medical record revilast updated April 1 at risk for falls second (history) of 5 recent balance and poor serview of the reside interventions to present a larm) to low (wheelchair)moniper plan"  Medical record reviewed resident near restroom pade confusion per usual (no)injury"  Interview with the and (DON) on May 8, 2 training room, contwithout injury on A care plan had not resident #115 was November 1, 2011 Care Involving use Parkinson's Diseas | ew of the Quarterly Minimum fed February 20, 2013, not was severely cognitively red extensive assistance with viving (ADLs).  ew of the resident's care plan, 2, 2013, revealed, "Resident ondary to d/t (due to) hx of falls, unsteady gait and safety awareness" Continued ent's care plan revealed event falls "psa (personal event falls "alarm sounding lying in floor on R (right) side is on floor low bed in use d/t ealbrief was soiled0  acting Director of Nursing 2013, at 9:00 a.m., in the firmed the resident had a fall pril 27, 2013, and the resident's been updated to reflect the cent fall.  s admitted to the facility on I, with admitting diagnoses of expanding the procedures, use, Paralysis Agitans, Chronic essential Hypertension, and |               | MDS Coordinator will maintain a monthly schedule of all residents whare due their periodic updates. An additional full time MDS coordinate previously part-time, has been addedleffective April 23, 2013 and assigned the MDS office to meet the assessments of the MDS coordinator, previoutilized since March, 2013, has also extended to ensure all indicated assessments are completed and are timely. Unit managers will periodic review residents plan of care for accuracy and will update the plan of care upon a noted decline in ADL's significant change in mental or phy status, the occurrence of an incident if hospitalization is required to add their condition. The Director of Nu and/or designee will report to the Nacoordinator any changes indicated resident's plan of care for approprupdates.  Monitoring of corrective actions:  Monitoring of corrective actions:  Monitoring of corrections will be continued, ongoing program utilishift supervisors and direct obserwhen conducting rounds on their designated shifts. MDS Coordinator designated shifts. | or, ed d to ent tion, ously been  ally of sical et, or ress rsing ADS in the iate |

| DEPAK<br>CENTE | MENT OF HEALTM        | AND HUMAN SERVICES  & MEDICAID SERVICES  |               |                  | F  |             | 05/14/2013<br>APPROVED     |
|----------------|-----------------------|--|---------------|------------------|--|-------------|----------------------------|
| STATEMENT      | OF DEFICIENCIES       | (X1) PROVIDER/SUPPLIER/CLIA  | 1             |                  |  |             | 0938-0391                  |
| AND PLAN C     | OF CORRECTION         | IDENTIFICATION NUMBER:   |               |                  | E CONSTRUCTION   | (X3) DAT    | E SURVEY<br>IPLETED        |
|                |                       | 445114   | B. WING       |                  |  | 0.51        | 00/2010                    |
| NAME OF P      | ROVIDER OR SUPPLIER   |  |               | STRE             | EET ADDRESS, CITY, STATE, ZIP CODE   | 1 05/       | 08/2013                    |
| BRAKEE         | ILL NURSING HOME      | INC.   |               | 58               | 37 LYONS VIEW PIKE<br>NOXVILLE, TN 37919   |             |                            |
| (X4) ID        | SUMMARY STA           | TEMENT OF DEFICIENCIES   | l 10          | — <sub>1</sub> . | <del></del>  | <del></del> |                            |
| PREFIX<br>TAG  | (EACH DEFICIENCY      | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | PREFIX<br>TAG | <b>,</b>         | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | n pe        | (X5)<br>COMPLETION<br>DATE |
| F 280          | Continued From pa     | ne 18  |               |                  | MDS Coordinator will maintain a  | manthly     | ·                          |
| ,              |                       |  | F 2           | 80               | schedule of all residents who are di   | ae their    | Į                          |
|                | dated November 2,     | ew of the resident's care plan   |               |                  | periodic updates. An additional ful  |             | ]                          |
|                | interventions were i  | mplemented after a significant   |               | 1                | MDS coordinator, previously part-  | time, has   |                            |
|                | weight loss of sever  | n percent from January   | -             | - }              | been added effective April 23, 2013  | and         |                            |
|                | through March 2013    | 3.   |               |                  | assigned to the MDS office to meet   | the         | ļ                          |
|                | -                     |  |               |                  | assessment schedules for each resid  |             | Ì                          |
|                | Interview with Licen  | sed Practical Nurse (LPN) #2   |               |                  | addition, a contract MDS coordina  |             |                            |
|                | on May 1, 2013, at    | 7:46 a.m., at the 400 hall   |               |                  | previously utilized since March, 20  |             |                            |
|                | nurse's station, con  | firmed the resident's care plan  |               |                  | also been extended to ensure all inc   |             |                            |
|                | nad not been updat    | ed to reflect any weight loss  |               |                  | assessments are completed and are  |             |                            |
|                | interventions, no int | erventions had been put in   |               |                  | Unit managers will review a sample   |             |                            |
|                | place until April 25, | 2013.  |               |                  | of units' residents' plan of care for  | accuracy    | !                          |
|                | Resident #210 was     | admitted to the facility on  |               |                  | weekly for 8 weeks for compliance  | and once    |                            |
|                | January 22, 2013, v   | vith admitting diagnoses of  |               | - 1              | per month thereafter if compliance   | 15          |                            |
|                | Anemia, Hypertensi    | ion. Hyperlipidemia  |               |                  | achieved. Unit manager and MDS<br>Coordinator will update the plan o   | £           | •                          |
|                | Cerebrovascular Ac    | cident, and Dementia.  |               |                  | upon a noted decline in ADL's, sign  |             |                            |
|                |                       |  |               |                  | change in mental or physical status  |             |                            |
|                | Medical record review | ew of the resident's care plan   |               |                  | occurrence of an incident, or if   | , Liie      |                            |
|                | revealed ," Potent    | tial for Weight Loss" dated  |               |                  | hospitalization is required to addre   | ss their    |                            |
|                | January 23, 2013, I   | and not been updated to reflect  |               |                  | condition. The Director of Nursing   |             |                            |
|                | interventions wars    | icant weight loss, and no new  |               |                  | designee will report to the MDS coo  |             |                            |
|                | THE VEHICLES WEIG     | ordered to prevent weight loss.  |               | - 1              | any changes indicated in the reside  | nt's plan   |                            |
|                | Interview with Assis  | tant Director of Nursing   |               |                  | of care for appropriate updates.   |             |                            |
|                | (ADON) at the 200     | hall nurse's station on May 1,   |               | ŀ                |  |             |                            |
|                | 2013, at 8:42 a.m.    | confirmed the resident's care  | ·             |                  | Monitorian Samuel  |             | i                          |
|                | plan had not been (   | updated to reflect weight loss   |               | -                | Monitoring of corrective actions:  |             |                            |
|                | interventions ordere  | ed on April 25, 2013.  |               |                  |  |             |                            |
|                | Resident #77          | and the state of t |               |                  | Monitoring of corrections will begin   | June 1.     |                            |
|                | March 17 2044         | admitted to the facility on  |               |                  | 2013 by Unit managers and MDS st   |             |                            |
|                | Failure to Thrive Al  | th diagnoses including Adult<br>Izheimer's Disease, Dementia,  |               |                  | be a continued, ongoing program ut   | ilizing     |                            |
|                | Concestive Heart      | allure, Atrial Fibrillation, and   |               |                  | shift supervisors and direct observa   | tions       |                            |
|                | Symptoms Concern      | ning Nutrition, Metabolism.  |               |                  | when conducting rounds on their de   |             |                            |
|                | 2 , 2 20110011        | Touridori, Micrapolisiii.  | 1             |                  | shifts. MDS Coordinators will also   | verify      |                            |
|                | Medical record revi   | ew of the Quarterly Minimum  |               |                  | accuracy and usage by direct observ  |             |                            |
|                | Data Sets (MDS) d     | ated September 10, 2012, and   | 1             |                  | and chart review in accordance to N  | 1DS         |                            |
|                |                       |  | 1             |                  |  |             |                            |

requirements and assessment schedule. In

| DEPART<br>CENTER         | MENT OF HEALTH   | AND HUMAN SERVICES  |                   |     |  | FORI   | D: 05/14/2013<br>M APPROVED            |
|--------------------------|--|---|-------------------|-----|--|--|--|
| STATEMENT                | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | 1                 |     | E CONSTRUCTION .   | (X3) DA  | O. 0938-0391<br>ATE SURVEY<br>OMPLETED |
|                          | AME OF PROVIDER OR SUPPLIER  RAKEBILL NURSING HOME INC.  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 280 Continued From page 19  December 7, 2012, revealed the resident was severely cognitively impaired, required extensassistance with one person physical assistant for eating, and had no weight loss or gain.  Medical record review of the nutritional progrante dated December 2, 2012 revealed the resident was not able to self. feed and the Idea Body Weight range was 81-99#.  Review of the weight record revealed the following weights:  1. January 25, 2013, weight 85.8 pounds (#).  2. February 26, 2013, weight 79.6#.  4. April 25, 2013, weight 74#, for a 5.6# loss 7% in 30 days from the March 21, 2013 weight Review of the physician orders revealed the following:  1. March 26, 2013, Nutritional supplement the times daily due to weight loss;  2. April 2013 Recapitulation Orders signed by the summer of the property of the programmer of the signed of the signed and the self-signed by the self-signed by the self-signed by the signed of the physician orders revealed the following:  1. March 26, 2013, Nutritional supplement the signed by the |   | B, WING           |     |  |  | 5/08/2013                              |
|                          |  | INC.  |                   | 58  | EET ADDRESS, CITY, STATE, ZIP CODE<br>337 LYONS VIEW PIKE<br>NOXVILLE, TN 37919  |  | 3/06/2013                              |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | MUST BE PRECEDED BY FULL  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)   | ID BE  | (X5)<br>COMPLETION<br>DATE             |
| F 280                    | December 7, 2012, severely cognitively assistance with one for eating, and had Medical record revinote dated Decembersident was not ab Body Weight range Review of the weighfollowing weights:  1. January 25, 2013, 2. February 26, 2013, 4. April 25, 2013, w 7% in 30 days from Review of the physicilan April 23, Salt, Mechanical Schigh Calorie Orangand Nutritional supa day.  3. April 25, 2013, a with meals, and we Medical record rev March 15, 2012, remarks 15, 2 | revealed the resident was impaired, required extensive a person physical assistance no weight loss or gain.  ew of the nutritional progress per 2, 2012 revealed the ple to self feed and the Ideal was 81-99#.  Intrecord revealed the self for a 5.6# loss or the March 21, 2013 weight.  Nutritional supplement three weight loss: | F2                | 280 | addition, the Director of Nursing an Administrator will also determine compliance utilizing direct observationart review samplings. All resident also be reassessed and care plan upoupon a noted decline in ADL's, signichange in mental or physical status, occurrence of an incident, or if hospitalization is required to addrescondition. In addition to the mornin admission meeting, MDS assessment plans and schedules will be reviewed monthly as an agenda item as a part QA/QI process. | ion and is will dated ificant the is their ig ts, care |  |

| CENTER                   | RS FOR MEDI <u>CARE</u>  | & MEDICAID SERVICES  |                   |      |   | FORM A    | 05/14/2013<br>PPROVED        |
|--------------------------|--|--|-------------------|------|---|-----------|------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                   |      | E CONSTRUCTION ON   | (X3) DATE | 0938-0391<br>SURVEY<br>LETED |
| <u>_</u>                 |  | 445114   | B. WING           |      |   | 0.240     |                              |
| NAME OF P                | ROVIDER OR SUPPLIER  | — <del>,—,</del> —   |                   | STRE | EET ADDRESS, CITY, STATE, ZIP CODE  | 05/0      | 8/2013                       |
| BRAKEB                   | ILL NURSING HOME   | INC.   |                   | 58   | 37 LYONS VIEW PIKE<br>NOXVILLE, TN 37919  |           |                              |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG | ıx   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY)   | BE 1      | (XS)<br>COMPLETION<br>DATE   |
| F 280                    | with sip of liquidof refused, food prefer weights and intake snacks and suppler review of the care puthe problem or apprecable. Interview with the action (DON) and the Medication Administ documentation of the administration.               | fer subs (substitutes) for food rencesenc po fluidsmonitor and document in chartoffer ments as ordered" Further lan revealed no changes to roaches since March 15, cting Director of Nursing lical Record Director on April m., in the training room, the 2013, and April 2013, tration Record did not have be nutritional supplement ther interview revealed the stopped in February 2013.              | F2                | 280  |   |           |                              |
| F 281<br>SS=D            | Interview with the and 2:25 p.m. in the train weight loss had not plan at the time of the and March, 2013.  483.20(k)(3)(i) SER PROFESSIONAL SERVICES provide must meet professional This REQUIREMENT by:  Based on medical Drug Information H | Registered Nurse #2 on May n., in the training room, care plans behind"  cting DON on May 7, 2013, at ning room, confirmed the been addressed on the care he loss in January, February, EVICES PROVIDED MEET TANDARDS  ded or arranged by the facility onal standards of quality.  It is not met as evidenced record review, review of the andbook for Nursing (2007), licy, and interview, the facility | F:                | 281  | F 281  It is the goal of Brakebill Nursing Rehabilitation Center to ensure the services provided or arranged by the facility will meet professional standards of quality.  Corrective action that will be accomplished for those residents found to have been affected: | and<br>e  | 6/21/13                      |

| STATEMENT OF DEFICIENCIES AND ELAND CORRECTION  (XI) PROVIDER SUPPLIER  445114  445114  3. WINS  STREET ADDRESS, CITY, STATE, 2P CODE  5337 LYONS VIEW PIME  KNOXVILLE, TN 37919  SUMMARY STATEMENT OF DEPROSENCE FILL  REGULATORY OR USC IDENTIFYING INFORMATION)  FORETHER  TAG  Continued From page 21  falled to follow facility protocol and physician order's for the treatment of constipation and failed to monitor for side-effects of an antipsychotic medication for one resident (#123), and failed to follow physician's orders for documentation of intake and output for one resident (#143), of sixty-four residents reviewed.  The findings included:  Resident #123 was admitted to the facility on November 15, 2012, with diagnoses including Abnormality of Galt, Generalized Pain, Aphasia, and Dementia with Behavioral Disturbance.  Medical record review of the quarterly Minimum Data Set (MDS) dated February 20, 2013, revealed the resident had received an anti-anxiety medication, an antipsychotic medication and was on a scheduled pain medication regimen.  Medical record review of the resident's Medication Administration regimen.  Medical record review of the resident's Medication and was on a scheduled pain medication, where the month of May, 2013, revealed the resident had received Kinonpin (anti-anxiety) medication, and the received Kinonpin (anti-anxiety) medication, and Lortal (narrootic pain medication), MS Contin (narrootic pain medication) and Lortal (narrootic pain medication) and Lo | DEFAIL<br>CENTE | INCINE OF HEALTH   | AND HUMAN SERVICES  & MEDICAID SERVICES   |         |  | FORM   | 05/14/2013<br>APPROVED |
|--|-----------------|--|---|---------|--|--|------------------------|
| MAME OF PROVIDER OR SUPPLIER  BRAKEBILL NURSING HOME INC.  KNOVILLE, TH 37919  SUMMARY STATEMENT OF DEFICIENCES SUPPLIED TO SET PROCESS OF THE PROPERTY OF DEFICIENCES STATE AND PROPERTY OF DEFICIENCES STATE AND PROPERTY OF DEFICIENCES STATE AND PROPERTY OF A SUMMARY STATEMENT OF DEFICIENCES STATE AND PROPERTY OF THE  | STATEMENT       | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA   |         |  | (X3) DAT   | E SURVEY               |
| STREET ADDRESS, CITY, STATE, ZIP CODE S37 LYONS YEW PIKE KNOXVILLE, TN 37819  SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY YEUL, TAG  TAG  CONTINUED FROM PAGE TAG  CONTINUED PREPRY TAG  PROVIDER'S PLAN OF CORRECTION PAGE TAG  CONTINUED PROVIDER'S PLAN OF CORRECTION PAGE TAG  PROVIDER'S PLAN OF CORRECTION PAGE TAG  CONTINUED PROVIDER'S PLAN OF CORRECTION PAGE TAG  PROVIDER'S PLAN OF CORRECTION PAGE TO THE APPROPRIATE  PROVIDER'S PLAN OF CORRECTION PAGE TO THE APPROPRIATE  PROVIDER'S PLAN OF CORRECTION PAGE TO THE APPROPRIATE  PROVIDER'S PLAN OF COINS POLICA PAGE TO THE APPROPRIATE  PROVIDER'S PLAN OF COINS PAGE TO THE APPROPRIATE  PROVIDER'S PAGE TO THE APPROPRIATE  PROVIDER'S PLAN OF COINS PAGE TO THE APPROPRIATE  PROVIDER'S PAGE TO THE APPROPRIATE  PROVIDER'S PLAN  |                 |  | 445114  | B. WING |  | 05/  | 00/2040                |
| SATE   SATE   SAMMARY STATEMENT OF DEFICIENCES   SATE   YOND VIEW PIKE   KNOXVILLE, TN 37919   | NAME OF P       | ROVIDER OR SUPPLIER  |   |         | STREET ADDRESS CITY PTATE  | U5/  | 08/2013                |
| PREFIX TAG  WASHINGTON OR LSC IDENTIFYING INFORMATION)  F 281  Continued From page 21 failed to follow facility protocol and physician order's for the treatment of constipation and failed to monitor for side-effects of an antipsychotic medication for one resident (#123), and failed to follow physicians orders for occurrentation of intake and output for one resident (#123), and failed to follow physicians orders for documentation of intake and output for one resident (#143) of sixty-four residents reviewed.  The findings included:  Resident #123 was admitted to the facility on November 15, 2012, with diagnoses including Abnormally of Gait, Generalized Pain, Aphasia, and Dementia with Behavioral Disturbance.  Medical record review of the Quarterly Minimum Data Set (MIDS) dated February 20, 2013, revealed the resident had received an anti-anxiety medication, an antipsychotic medication, an antipsychotic medication, and was on a scheduled pain medication regimen.  Medical record review of the Courterly Minimum Data Set (MIDS) dated February 20, 2013, revealed the resident fad received the resident had received an anti-anxiety medication, Administration Record (MAR) for the month of May, 2013, revealed the resident had received the resident facility on the particle of the resident facility on the particle of the particle of the resident facility on the particle of the pa | BRAKEB          |  |   |         | 5837 LYONS VIEW PIKE   | ZIP CODE   |                        |
| failed to follow facility protocol and physician order's for the treatment of constipation and failed to monitor for side-effects of an antipsychotic medication for one resident (#123) and failed to follow physician's orders for documentation of intake and output for one resident (#143) of sixty-four residents reviewed.  The findings included:  Resident #123 was admitted to the facility on November 15, 2012, with diagnoses including Abnormality of Galt, Generalized Pain, Aphasia, and Dementia with Behavioral Disturbance.  Medical record review of the Quarterly Minimum Data Set (MDS) dated February 20, 2013, revealed the resident had received an anti-anxiety medication, an antipsycholic medication, and was on a scheduled pain medication regimen.  Medical record review of the resident's Medication Administration Record (MAR) for the month of May, 2013, revealed the resident had received Klonophin (anti-anxiety medication), Seroquel (antipsychotic medication), MS Contin (narcotic pain medication), and Lorate (narcotic p | PRÉFIX          | I (EACH DEFICIENCY   | MUST BE PRECEDED by all t   | PREF    | PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T  | ACTION SHOULD BE<br>FO THE APPROPRIATE   | COMPLETION             |
| Data Set (MDS) dated February 20, 2013, revealed the resident had received an anti-anxiety medication, an antipsychotic medication, and was on a scheduled pain medication regimen.  Medical record review of the resident's Medication Administration Record (MAR) for the month of May, 2013, revealed the resident had received Klonopin (anti-anxiety medication), MS Contin (narcotic pain medication), Morphine IR (narcotic pain medication), and Lortab (narcotic pain medication) on a daily basis.  Review of Drug Information Handbook for Nursing (2007) revealed the anti-anxiety medication, the antipsychotic medication, and the narcotic pain medications all had an increased risk for constipation.  Residents receiving antipsychotic medication and the narcotic pain medications all had an increased risk for constipation.   | F 281           | failed to follow facility order's for the treater to monitor for side-emedication for one follow physician's orintake and output for sixty-four residents.  The findings includes Resident #123 was November 15, 2012 Abnormality of Gait, and Dementia with   | ty protocol and physician ment of constipation and failed effects of an antipsychotic resident (#123), and failed to rders for documentation of or one resident (#143) of reviewed.  ed:  admitted to the facility on the diagnoses including Generalized Pain, Aphasia, Behavioral Disturbance.  | F 2     | related to constipation AIMS Scale assessment by Psychiatric PhD rela medications have been follow-up scheduled wi normal course of reside treatment.  Resident # 143: Currer is now addressed and d according to physicians   | on May 5, 2013.  It and documentation ated to antipsychotic addressed and Ith Psychiatric PhD in ents on-going  It intake and output documented s order.   |                        |
| Medical record review of the resident's ADL (activities of daily living) Flow Record for the  ORM CMS-2567(02-99) Previous Versions Obsolete  Teviewed for AIMS testing by unit managers. Director of Nursing and/or Assistant Director will conduct in-services for all nursing staff regarding monitoring  |                 | Data Set (MDS) data revealed the resider medication, an antipon a scheduled pair Medical record revision Medical record revision Administration Administration Administration Administration (Seroquel (antipsychonarcotic pair medication), and medication) on a data Review of Drug Information (2007) revented in the antipolic pair medication, the antipolic pair medication and medication arcotic pair medication medicatio | ned February 20, 2013, and had received an anti-anxiety psychotic medication, and was a medication regimen.  The work of the resident's tration Record (MAR) for the stration Record (MAR) for the stration, MS Continuation, MS Continuation, Morphine IR (narcotic ad Lortab (narcotic pain ally basis.  The properties of the stration of the stration and the strations all had an increased the resident's ADI |         | Record review of reside antipsychotic medication monitoring of intake are conducted by Unit man psychiatric PhD was rewere identified.  Measures to be put in pechanges:  Residents receiving ant medications and/or received for AIMS test managers. Director of it Assistant Director will | ents receiving ons, orders for od output was nagers and/or viewed. No problems  place and systemic  ipsychotic eiving psychiatric ic PhD will be ting by unit Nursing and/or conduct in-services |                        |

|                          |  | AND HUMAN SERVICES  & MEDICAID SERVICES  |                      |     |   | FORM   | 05/14/2013<br>APPROVED        |
|--------------------------|--|--|----------------------|-----|---|--|-------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MUL<br>A. BUILD |     | CONSTRUCTION  | (X3) DATE  | 0938-0391<br>SURVEY<br>PLETED |
|                          |  | 445114   | B. WING              |     |   | 05/0   | 18/2013                       |
| BRAKEE                   | ROVIDER OR SUPPLIER  ILL NURSING HOME  |  |                      | 58  | EET ADDRESS, CITY, STATE, ZIP CODE<br>37 LYONS VIEW PIKE<br>NOXVILLE, TN 37919  |  | 7072010                       |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG   |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD I<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY)   | BF !   | (X5)<br>COMPLETION<br>DATE    |
| F 281                    | for the documentatic Continued review of month of May, 2013 the resident had a treatment and may 5, 2 Medical record review of the month of May, 2 given to promote B signed and dated Novemb Constipation Dulcolax (5) milling suppository, daily the Magnesia (30) milling suppository, daily | ge 22 3, revealed designated spaces fon of bowel function per shift. If the ADL Flow Record for the 3, revealed no documentation powel movement from May 1, 2013, for a total of four days.  ew of the resident's MAR for 2013, revealed "laxative M (bowel movement)"  May 5, 2013, at 2:00 p.m.  ew of Routine Orders signed for 16, 2012, revealed, "3.  gram tablet or (10) milligram fines (2) days or Milk of diliters daily times (2) days"  Insed Practical Nurse (LPN) #8 3:48 p.m., at Green Wing 300 revealed facility protocol for agement of constipation is no documented bowel lik of Magnesia (MOM) should result then suppository is to be #8 on May 8, 2013, at 10:11 ay, confirmed the ADL Flow ident had no documentation the wel movement until May 5, ing shift. Further interview with the confirmed the resident was astipation "because (the litiple pain meds" Continued I #8, confirmed the nurses nt's bowel function by reviewing the soule function by reviewing the soule function by reviewing the previous process of the soule function by reviewing the previous process of the soule function by reviewing the previous process of the soule function by reviewing the previous process of the soule function by reviewing the previous process of the soule function by reviewing the previous process of the soule function by reviewing the previous process of the soule function by reviewing the previous process of the soule function by reviewing the previous process of the soule function by reviewing the previous process of the soule function by reviewing the previous process of the soule function by reviewing the previous process of the soule function by reviewing the previous process of the soule function by reviewing the previous process of the soule function by reviewing the previous process of the soule function by reviewing the previous process of the soule function by reviewing the previous process of the soule function by reviewing the previous process of the soule function process of the soule function process of t |                      | 281 | and documentation of bowel movements and documentation requirements relationate and output requirements on resiwith specified physician orders. In-service will be conducted within the 45 day per allowed in the 2567 or by June 22, 2013.  Monitoring of corrective actions:  Unit managers and/or shift supervisors responsible foe ensuring adherence to documentation requirements. Log will i maintained by social services for those receiving psychiatric services. Director Nursing and/or Assistant or unit managemonitor a sample of 20% of units' residuely for 8 weeks for compliance and month thereafter if compliance is achieved service training will be used to educate on requirement to adhere and report and deviations in bowel policy requirements licensed nursing staff for appropriate interventions.  In-services will be conducted by the DON/ADON within the 45 day period allowed in the 2567 or by June 22, 2013. Psychiatric services log management were viewed monthly in the QA/QI meeting addition to MDS resident listing to mon residents receiving antipsychotic medic who are being monitored for 1&O. | ing to idents vices vices viol 5.  will be residents of ges will dents' once per ved. In-Cna's to vill be g in aitor |                               |

PRINTED: 05/14/2013

|                          |  | AND HUMAN SERVICES  & MEDICAID SERVICES   |                   |      |   |       | FORM A               | 05/14/2013<br>PPROVED      |
|--------------------------|--|---|-------------------|------|---|-------|----------------------|----------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                   |      | CONSTRUCTION  |       | (X3) DATE S<br>COMPL |                            |
|                          |  | 445114  | B. WING           |      |   |       | UE IU I              | 2/2042                     |
| NAME OF P                | ROVIDER OR SUPPLIER  | · <del></del>   | <u> </u>          | STRE | ET ADDRESS, CITY, STATE, ZIP CODE   |       | USIUR                | 3/2013                     |
| BRAKEE                   | ILL NURSING HOME   | INC.  |                   |      | 37 LYONS VIEW PIKE<br>NOXVILLE, TN 37919  |       |                      |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |      | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | CHUON | RF !                 | (X5)<br>COMPLETION<br>DATE |
| F 281                    | #8, confirmed the retreatment for constite trecorded bowel mo protocol for manage constipation had not be made and protocol for manage constipation had not be made and protocol for manage constipation had not be made and protocol for manage and protoco | rd. Further interview with LPN esident had not received ipation until the fifth day of no vement, and the facility ement and treatment for ot been followed.  ew of the Quarterly Minimum ted February 20, 2013, in had received an cation.  ew of the resident's MAR and had received Seroquel (an cation) 50 mg at 4 p.m. and at basis.  iew of an Abnormal Involuntary AIMS), a scale to monitor for tentially permanent antipsychotic medication, nentation for the AIMS scale in |                   | 281  |   |       |                      |                            |

| CENTE                    | RS FOR MEDICARE   | & MEDICAID SERVICES   |                   |     |   | FORM     | APPROVED                         |
|--------------------------|---|---|-------------------|-----|---|----------|----------------------------------|
| STATEMEN                 | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDERSUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                   |     | PLE CONSTRUCTION  | (X3) DAT | 0938-0391<br>E SURVEY<br>IPLETED |
|                          |   | 445114  | B. WING           | 3   |   |          |                                  |
|                          | PROVIDER OR SUPPLIER  |   | <del></del>       | ST  | REET ADDRESS, CITY, STATE, ZIP CODE   | 05/      | 08/2013                          |
| BRAKE                    | BILL NURSING HOME   | INC.  |                   | 1 5 | 5837 LYONS VIEW PIKE<br>KNOXVILLE, TN 37919   |          |                                  |
| (X4) ID<br>PREFIX<br>TAG | I LEACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREP<br>TAG | ix  | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | N DE     | (X5)<br>COMPLETION<br>DATE       |
| F 281                    | confirmed the AIMS completed at any tir at the facility. Conticonfirmed the reside completed at least cadmission to the facility's protocol for antipsychotic medic Resident #143 was March 19, 2013 with Congestive Heart Fadementia.  Medical record revied ated April 17, 2013 "Strict I & O ( intake Medical record revied over various shifts for resident's intake.  Review of facility Poand Output Record revealed recorded accurately order or when medic review of facility poliwith specific physicis Outputs (I&O) will have eight hours regardles Interview with the act 8:28 a.m., in the trainesident's intake was resident's intake was res | esident upon admission to the prview with the DON also is scale had not been me during the resident's stay nued interview with the DON ent should have had an AIMS once since the resident's cility, and confirmed the monitoring of an ation had not been followed.  In admitted to the facility on a diagnoses including ailure, Pneumonia, and easy of a physician's order for the and output)"  In a diagnoses including ailure, Pneumonia, and easy of the resident's Intake aled multiple blank spaces or the documentation of the easy of of the e | F                 | 281 | DEFICIENCY)   |          |                                  |
|                          |   | medical record. Continued   |                   |     |   |          | •                                |
| RM CMS-25                | 67(02-99) Previous Versions   | Obsolete Synol ID: ECL 14   |                   |     | <u> </u>  |          | !                                |

... T. ... SELLA INDIVIDIO DERVICES

| CEW1E       | RS FOR MEDICARE   | TAIND HUMAN SERVICES   |                    |                | F  | RINTED    | 0: 05/14/2013<br>MAPPROVED           |
|-------------|---|--|--------------------|----------------|--|-----------|--------------------------------------|
| DIMIEMEN    | II OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) ML<br>A. BUIL | JLTIPI<br>DING | FE COMPTRUCTION  | (X3) DA   | ), 0938-0391<br>TE SURVEY<br>MPLETED |
| NAME OF     |   | 445114   | B. WING            | G              |  |           |                                      |
|             | NAME OF PROVIDER OR SUPPLIER  BRAKEBILL NURSING HOME INC.  (XI) ID PRETX  F 281  Continued From page 25  Interview with the DON, at that time, confirmed the facility's policy for documenting intake, and the physician's order for documenting and monitoring intake had not been followed.  SS=D  A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.  This REQUIREMENT is not met as evidenced by:  Based on medical record review and interview, the facility failed to provide restorative nursing services as ordered for one resident (#123) of sixty-four residents reviewed.  The findings included:  Resident #123 was admitted to the facility on November 15, 2012, with diagnoses including Abnormality of Gait, Generalized Pain, Aphasia, and Dementia with Behavioral Disturbance.  Medical record review of Quarterly Minimum Data Set (MDS) dated February 20, 2013, revealed the resident was severely cognitively impaired and required extensive assistance with all activities of daily living (ADLs).  Medical record review of Plan of Treatment for Outpatient Rehabilitation note, not dated, revealed, " Pt (patient) diced (discharged) from PT (physical thorappy) services on 12/17/12 RNA (Restorative Norwing as desirated" discincted diagnosis as listed During this period of time resident in circums debahavioral poisous of comments and incincted other than "softented" discintaged from PT (physical thorappy) services on 12/17/12 RNA (Restorative Norwing accident was discharged from the services of the proposed of time resident in circums debahavioral poisous of comments with all activities of cally living, dassistant) to amb | 05   | /08/2013           |                |  |           |                                      |
| BRAKE       | BILL NURSING HOME   | INC.   |                    | ۱ ۲            | COLLICIUS AIEM BIKE  |           |                                      |
|             | SUMMARY STA   | TEMENT OF DEFICIENCIES   | 1 100              |                | ·  |           |                                      |
|             | TEACH DEPUBLICATION OF  | MUST BE DOCOMBE  | PREF               | 1X             | CROSS-REFERENCED TO THE APPROP   |           | (X5)<br>COMPLETION<br>DATE           |
| F 281       | Continued From pa   | ge 25  | F 2                | 281            |  | <u> </u>  | <u> </u>                             |
| F 311       | the physician's orde<br>monitoring intake ha  | or documenting intake, and or for documenting and and not been followed.                                 |                    |                |  |           | 6/21/13                              |
| SS=D        | IMPROVE/MAINTA  | N ADLS   | F 3                | 311            | F 311  |           | ı                                    |
|             | ACLAICES IN LUGINISME   | Of Improve his or has allow  |                    |                | Brakebill Nursing and Rehabilitation<br>Center subscribes to the standard that a<br>resident is given the appropriate treatm<br>and services to improve his or her abilit  | ent       |                                      |
|             | υy,   | <b>†</b>   |                    |                | Corrective action:   |           |                                      |
|             | services as ordered   | for one resident (#122) -c   |                    |                | Resident # 123: Resident was admitted to facility as indicated on November 15, 20 with a diagnosis including abnormality of Gait, Generalized Pain, Aphasia, Demen   | 12<br>of  |                                      |
|             | The findings include  | d:   |                    |                | with Behavioral Disturbances, Severe Cognitive Impairment and Extensive  |           |                                      |
|             | Abnormality of Gait   | With diagnoses including   |                    |                | Living. Resident received Physical There services but was discharged from their services on 12/17/2012 due to meeting the  | eir       | į                                    |
|             | resident was severel<br>required extensive a  | V cognitively impaired and   |                    |                | from further treatment. Resident was<br>discharged to Restorative Nursing Service<br>to ambulate patient as tolerated. Physica<br>Therapy orders and treatment Record<br>dated and signed December 18, 2012 state  | ces<br>I  |                                      |
| Div Chic or | revealed, "Pt (patie<br>PT (physical therapy<br>(Restorative Nursing<br>(ambulate) pt as tole   | ition note, not dated,<br>int) d/c'd (discharged) from<br>) services on 12/17/12RNA<br>Assistant) to amb |                    |                | specific time frames or frequency was indicated other than "as tolerated" due t residents advanced diagnosis as listed.  During this period of time resident exhibincrensed behavioral episodes of combatibehavior, inconsolable episodes of anger and anxiety, refusal of medications and | o<br>ited |                                      |

| _ CENTE       | RS FOR MEDICARE   | MEDICAID SERVICES   |               |   |  | ): 05/14/2013<br>1APPROVED |
|---------------|---|---|---------------|---|--|----------------------------|
| STATEMENT     | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |               | TIPLE CONSTRUCTION  | OMB NC<br>(X3) DA  | . 0938-0391<br>FE SURVEY   |
| <u></u>       |   | 445114  | B. WING       |   |  |                            |
| NAME OF F     | PROVIDER OR SUPPLIER  |   | <u> </u>      | STREET ADDRESS STREET   |  | /08/2013                   |
| BRAKEE        | BILL NURSING HOME   | INC.  |               | STREET ADDRESS, CITY, STATE, ZIP<br>5837 LYONS VIEW PIKE<br>KNOXVILLE, TN 37919   | CODE   |                            |
| (X4) ID       | SUMMARY STA   | TEMENT OF DEFICIENCIES  |               | <del></del>   |  |                            |
| PREFIX<br>TAG | (EACH DEFICIENCY  | MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | PREFIX<br>TAG | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACT)<br>CROSS-REFERENCED TO T<br>DEFICIENCE  | ON SHOULD BE<br>HE APPROPRIATE   | (X5)<br>COMPLETION<br>DATE |
| F 312         | Medical record revie Physical Therapy O dated and signed D "RNA to Amb pt a Medical record revie Record Restorative 2012, revealed the reservices for ambula 20, 2012, out of nine Medical record revie Record Restorative 2013, revealed the reservices for ambula twenty-two days.  Medical record revie Record Restorative 2013, revealed the restorative services month.  Interview with Restorative services month.  Interview with Restorative Record Restorative services month.  Interview with Restorative 2013, revealed the restorative services month.  Interview with Restorative Services months. Con Service Record Restorative services those months. Con Restorative Nursing time, confirmed the restorative nursing services to service to service the restorative nursing services restorative nursing se | ew of Occupational and rders and Treatment Record, ecember 18, 2012, revealed, stol (as tolerarted)"  ew of Daily Patient Service for the month of December, resident received restorative tion on one day, December edays.  ew of Daily Patient Service for the month of January, resident received restorative tion on four days out of  ew of Daily Patient Service for the month of February, resident received no for ambulation for the entire entire for ambulation for the entire firmed the Daily Patient etorative for the months of anuary, 2013, and February, ected the number of the resident had received for tinued interview with Assistants #1 and #2, at that resident had not received services as ordered.  ARE PROVIDED FOR | F 31          | numerous visits by family to Resistance to care is also not documented. Physician inter also noted with the addition Klonapin, and increased pair including morphine. This confactors would account for resinability to want or receive R during the time frame indica now capable of participate in and is now receiving services 2013.  Identification:  On record review by DON & manager, no other residents  Measures to be put in place changes:  No specific or systemic chan indicated or warranted in the time due to resident's lack of participate in RNA services.  Monitoring of corrective actindicated due to resident's he condition and uncontrollable during this period of time. Receiving extensive medical | intervene. ed and ventions are of Tramadol, a management abination of sident's NA services ted. Resident is a RNA services a since March  therapy were identified.  and systemic ges are e system at this f ability to  actions: ions is not istory, severe e behaviors tesident was and psychiatric litions and |                            |
| DDM Chin      |   |   |               |   |  |                            |
|               | 67(02-99) Previous Versions   |   |               | Facility ID: TN4702   | If confinential at   | D 67 67                    |
| p-eri         | mission given   | by adm on 6/10/13   | 11:10p        | m to accid to F311;   | If continuation sheet  | rage 2/ of 58              |

when a residents' condition changes where a resident count or won't participate in rehab, Restorative will be put on hold and restarted when the resident can participate.

monitoring: Restorative services will monitor any residents who are put on food to ensure services are resumed when resident can participate.

MADYLE PHNC-II

|                          |   | AND HUMAN SERVICES  |                   |      |  | 05/14/2013<br>APPROVED     |
|--------------------------|---|---|-------------------|------|--|----------------------------|
|                          | S FOR MEDICARE OF DEFICIENCIES  | & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA  | (X2) MUI          | TIPI |  | 0938-0391<br>SURVEY        |
|                          | F CORRECTION  | IDENTIFICATION NUMBER:  |                   |      |  | PLETED                     |
|                          |   | <br>  445114  | B. WING           | ·    |  | 08/2013                    |
| NAME OF P                | ROVIDER OR SUPPLIER   |   |                   | STF  | REET ADDRESS, CITY, STATE, ZIP CODE  | 00,2010                    |
| BRAKEB                   | ILL NURSING HOME  | INC.  |                   | 5    | 837 LYONS VIEW PIKE<br>KNOXVILLE, TN 37919   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | NTEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC (DENT(FYING INFORMATION)  | ID<br>PREF<br>TAG | ΊX   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  | (X5)<br>COMPLETION<br>DATE |
| F 312                    | daily living receives   | age 27 nable to carry out activities of sthe necessary services to ition, grooming, and personal  | F                 | 312  | according to "RNA to AMB pt as tol<br>(tolerated)" order. Future refusals by<br>resident will be documented by RNA<br>services.  |                            |
|                          | by: Based on medical facility policy revier falled to maintain president (#150) of The findings included Resident #150 was August 21, 2008, Failure to Thrive, Vertigo, and Histom Medical record redata set dated De resident scored to Interview for Menicognitive impairm the resident requi | s admitted to the facility on with diagnoses including Adult Hypertension, Osteoporosis, ry of Falls.  view of the quarterly minimum ocember 16, 2012, revealed the velve out of fifteen on the Brief tal Status indicating moderate ent. Continued review revealed red extensive assistance from ansfers, dressing, personal |                   |      | Brakebill Nursing and Rehabilitation Center supports the standard that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral care.  Corrective action:  Resident # 150: Residents finger nails were cleaned and trimmed during the shift condition was noted by a licensed nurse. Interview with resident revealed this was an isolated incident as resident confirmed "the staff usually trimmed the fingernails when they needed trimming". | 6/01/13                    |
|                          |   | ident's care plan dated<br>012, revealed, "Resident with  |                   |      | ldentification:  |                            |

self-care deficits secondary to limited ambulation

with shower; clip fingernails q (every) 2 weeks..."

and falls risk...Interventions...Clean fingernails

Review of the facility's, Policy for Nail Care, revealed, "It is the policy of (facility name) that all

being effected.

Based on observation by nursing staff, no

other resident was noted or identified as

| DEPART                   | MENT OF HEALTH   | AND HUMAN SERVICES  & MEDICAID SERVICES   |                   |       |   | FORM A   | PPROVED<br>938-0391        |
|--------------------------|--|---|-------------------|-------|---|--|----------------------------|
| TATEMENT C               | DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                   |       | CONSTRUCTION  | (X3) DATE<br>COMP  | SURVEY<br>LETED            |
|                          |  | 445114  | B. WING           |       |   | 05/0   | 8/2013                     |
| NAME OF PR               | OVIDER OR SUPPLIER   |   |                   | i     | ET ADDRESS, CITY, STATE, ZIP CODE<br>7 LYONS VIEW PIKE  |  |                            |
| BRAKEBI                  | LL NURSING HOME  | INC.  |                   |       | OXVILLE, TN 37919   |  |                            |
| (X4) ID<br>PREFIX<br>TAG | (FACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |       | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)   | DBE  | (X5)<br>COMPLETION<br>DATE |
| F 312                    | fingernails will be of and toenails clipped. Observation on Appreciate the resident seated in revealed the resident had be a little trimming                                       | by devided by a License nurse. All clipped every two (2) weeks, and every month."  oril 29, 2013, at 3:50 p.m., of the a chair in the resident's room ent 's fingernalls were long, rown debris under the nails.  resident at this time confirmed immed the fingernalls when ning, and the nails "could use |                   | 312   | Measures to be put in place and syste changes:  Directed In-service Indicated. Direct Nursing/Assistant director of Nursin service all direct care staff to monitor report to licensed nursing staff any in need of nail care. Cna's will visual condition of residents nails during scheduled shower times and report observations needing care. In-service be conducted within the 45 day periallowed in the 2567 or by June 22, 2  | or of g will in or and resident lly note any sees will od 2013.                            |                            |
| F 318                    | Nurse (LPN) #6 of the resident's roofingernails were letter nails. Continue confirmed the nails be soaked and transfer assessment, the resident who en indwelling catheterization. | ATHETER, PREVENT UTI,   |                   | F 315 | Monitoring of corrective actions:  Monitoring for compliance will cor Cna observation and reporting duradministration of personal care an residents shower times. Licensed n also ensure compliance using direct observation during daily medication The Director of Nursing and/or un managers will observe a 15% sam residents on each hall for 8 weeks compliance. If compliance is indice sample will consist of 10% of uni population on a monthly basis the Compliance will be reviewed mon during the QA/QI meeting begint 6/1/2013. | esist of ring d during urses will et on passes. hit ple of for ated, t's residen creafter. | -                          |

treatment and services to prevent urinary tract infections and to restore as much normal bladder

| DEPART                   | MENT OF HEALTH   | AND HUMAN SERVICES  & MEDICAID SERVICES  |              |  | FORM   | 05/14/2013<br>APPROVED     |
|--------------------------|--|--|--------------|--|--|----------------------------|
| STATEMENT                | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |              | PLE CONSTRUCTION   | MB NO. 0938-0391<br>(X3) DATE SURVEY<br>COMPLETED  |                            |
|                          | A BUILDING  445114  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 5837 LYONS VIEW PIKE KNOXVILLE, TN 37919  C (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  COntinued From page 29 function as possible.  F 315  Continued From page 29 function as possible.  F 315  Brakebill Nursing and Rehabilitation Center supports the standard that based on the resident's comprehensive assessment, the facility policy, observation, and interview, the facility failed to complete a bladder assessment for one (#254) resident, failed to obtain a physician order and a supporting diagnoses for a catheter for one (#267) resident and failed to remove an indwelling urinary catheter for one   |  | 0.51         | 20/0040  |  |                            |
|                          |  | INC.   |              | 5837 LYONS VIEW PIKE   | 1 05/  | 08/2013                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ' MUST BE PRECEDED BY CHIL   | ID<br>PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES OF THE | CAE  | (X5)<br>COMPLETION<br>DATE |
| F 315                    | This REQUIREMENT by: Based on medical facility policy, obser facility failed to comfor one (#254) resident facility failed to comfor one (#254) resident order and catheter for one (#2 remove an indwellir (#156) resident of some time of some time of some time of some time of some of som | NT is not met as evidenced record review, review of the vation, and interview, the uplete a bladder assessment lent, failed to obtain a la supporting diagnoses for a 267) resident and failed to no urinary catheter for one sixty-four residents reviewed. | F 315        | Brakebill Nursing and Rehabilitation Center supports the standard that base the resident's comprehensive assessme the facility must ensure that a resident enters the facility without an indwellin catheter is not catheterized unless the resident's clinical condition demonstra that catheterization was necessary; and resident who is incontinent of bladder receives appropriate treatment and ser  | nt, who g tes d a rvices to ction rect orunry ress | 6/21/13                    |

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/14/2013 FORM APPROVED OMB NO. 0938-0391

| TATEMENT OF DEFICIENCIES (X1) ND PLAN OF CORRECTION      |  |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  |   | (X3) DATE SURVEY<br>COMPLETED   |                            |  |
|--|--|--|--|--|---|---|----------------------------|--|
|  | 445114   |  |  | B. WING  |   |   | 8/2013                     |  |
| NAME OF PROVIDER OR SUPPLIER BRAKEBILL NURSING HOME INC. |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE 5837 LYONS VIEW PIKE KNOXVILLE, TN 37919 |   |   |                            |  |
| (X4) ID<br>PREFIX<br>TAG                                 | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG                      |  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY)   | D BE  | (X5)<br>COMPLETION<br>DATE |  |
| F 315  | February 1, 2013 (and) B (bowel ar and change: upo meals; at HS (be (hours) during sleet to toilet or bed partial to toil | eview of the care plan dated, revealed "Resident with B and bladder) incontinencecheck in rising; before and/or after dtime); and Q (every) 2-3 hrs eep hrs"  cility policy, Bowel and Bladder ed) revealed, "Take the resident an at every 2-hour interval. Time ed as control is gained. ents to hold urine until specified ossible, and they get protocol for and bladder continence  y 1, 2013, at 2:00 p.m., with the of Nursing (DON), in the training in o bladder assessment had to determine if the resident was an individualized bladder training by 1, 2013, at 3:50 p.m. with the Director of Nursing (ADON), in the dowel and bladder reto be done on admission, ith a significant change in the |  | 315  | Measures to be put in place and system changes:  Directed In-service Indicated. Directo Nursing/Assistant director of Nursing service all direct nursing staff regardicompletion of a bladder assessment at obtaining a physician's order with supporting diagnosis for use of an indwelling catheter. Staff will also recin-service training by DON/ADON regarding the removal of indwelling catheters according to physician ordeservices will be conducted within the allowed in the 2567 or no later than 2013.  Monitoring of corrective actions:  Monitoring for compliance will be accomplished by identification of reson each nursing unit by unit manage and/or supervisors. The MDS listing residents with a catheter will be utilimonitor resident's code as having an indwelling catheter to ensure contin care and review of physicians order regarding catheter care. The Direct Nursing and/or ADON and MDS Coordinator will review coding of rwith indwelling catheters during we care plan meeting and verify validit bladder assessments, physician order supporting diagnosis and adherence physician orders for continued use. of 672 for conditions of residents will review to the physician orders for continued use. | er of will in ing and erive ers. In- period June 22, sidents ers of ized to a uity of s or of esidents eskly y of cers, e to Review |                            |  |

|  |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |  |     |   | FORM.                         | 00/14/2013<br>APPROVED<br>0938-0391 |  |
|--|--|--|--|-----|---|-------------------------------|-------------------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |     |   | (X3) DATE SURVEY<br>COMPLETED |                                     |  |
| 445114   |  |  | B. WING                                | ·   |   | 05/08/2013                    |                                     |  |
| NAME OF PROVIDER OR SUPPLIER BRAKEBILL NURSING HOME INC. |  |  |  | 58: | EET ADDRESS, CITY, STATE, ZIP CODE<br>37 LYONS VIEW PIKE<br>NOXVILLE, TN 37919                        | • •                           |                                     |  |
| (X4) ID<br>PREFIX<br>TAG                                 | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG                      |     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | _D BE                         | (X5)<br>COMPLETION<br>DATE          |  |
| F 315  | 2013, at 8:32 a.m., 2013, at 3:33 p.m., and May 8, 2013, a chair.  Medical record revial April 10, 2013, revealed no orders.  Medical record revial April 10, 201 revealed no orders.  Medical record revial at a completed by a nuithe indwelling Carresident was not in did not have a stagnosis of the catheter was removed an exact methave a diagnosis of the catheter was removed an exact methave a history of both catheter was removed in the catheter wa | o, 2013, at 8:26 a.m., May 1, while in bed; and May 1, May 7, 2013, at 3:40 p.m., at 8:35 a.m., while in a wheel lew of the nursing note dated ealed "foley catheter attached lew of the physician orders 3 through May 8, 2013, a for a catheter.  I iew of the Resident Data Set, rse, dated April 10, 2013, of theter Evaluation" revealed the a coma, was not terminally ill, ge 3 or 4 pressure ulcer, did not asurement of urine, did not asurement of urine, did not asurement of urine, did not asurement an appropriate sis. Further review revealed ere marked "No" and there is no osis. The resident is a potential sing, restorative/rehabilitation, or orgram" Further review of the trevealed the urological section d.  7, 2013, at 4:45 p.m., at the 400 th Licensed Practical Nurse PN #11, confirmed there was no |  | 315 | reviewed monthly during the QA/QI meeting beginning 6/1/2013.   |                               |                                     |  |

Interview on May 8, 2013, at 9:45 a.m., in training

| CENTE  | RS FOR MEDICARE   | & MEDICAID SERVICES   |   |                  |   | FC   | RM APPROVED |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MU<br>A. BUIL  | JLTIF<br>DIN(   | PLE CONSTRUCTION | I   | OMB NO. 0938-0391<br>(X3) DATE SURVEY<br>COMPLETED |             |
|  |   | <br>  445114  | B. WING   | 3                | _   |  |             |
| NAME OF F  | ROVIDER OR SUPPLIER   |   | <u> </u>  | ST               | REET ADDRESS, CITY, STATE, ZIP CODE         | <u>,                                 </u>          | 05/08/2013  |
| BRAKEE<br>——-  | BILL NURSING HOME   |   |   | 1                | 5837 LYONS VIEW PIKE<br>KNOXVILLE, TN 37919 |  | }           |
| (X4) ID<br>PREFIX<br>TAG   |   |   | ID PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION SI TAG CROSS-REFERENCED TO THE AF DEFICIENCY) |                  | OURDE                                       | (X5)<br>COMPLETION<br>DATE                         |             |
| F 315  | confirmed the facility catheters. Further in diagnosis to support and no physician or admission April 10,  Resident #156 was November 5, 2012, Dementiawith Behalt Rheumatoid Arthritis Artery Disease with seizures, recent ons Disease, Osteoporo Irritable Bowel Syndom Review of the Order Physician's Orders of revealed, "Foley of wound heals" Co Progress Note date revealed, "Pt (pat will place foley to he Observation on April the resident's room, indwelling catheter in drainage and covered Interview with the witherapist in the train 8:40 a.m., confirmed admitted with wound November 5, 2012. confirmed the physical decrease moisture to wound healing. Confirmed the physical | stant Director of Nursing by had no policy addressing interview confirmed no it a catheter upon admission, der for the catheter at 2013, through May 8, 2013.  admitted to the facility on with diagnoses including navioral Disturbances, is, Diabetes Mellitus, Coronary stent, Epilepsy (history of set) Gastroesophageal Reflux esis, Hypertension, and frome.  It is and Progress Notes, dated December 12, 2012, catheter with routine care until portinued review of the diagnose of the diagnose.  If 29, 2013, at 10:15 a.m., in revealed the resident had an in place connected to bedside ed with a privacy bag.  Justicial Standard | F   | 315              | DEFICIENCY)                                 |  |             |
| ORM CMS-26   | 67(02-99) Previous Vessland   |   | <del>'</del>  |                  | <u> </u>                                    | _  | 1           |

|   |  | AND HUMAN SERVICES  & MEDICAID SERVICES   |                   |              |   | FORM   | D: 05/14/2013<br>MAPPROVED |
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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION DENTIFICATION NEW PROVIDER/SUPPLIER/CLIA |  |   |                   | CONSTRUCTION | (X3) DA   | 0. 0938-0391<br>TE SURVEY<br>MPLETED           |                            |
|   |  | 445114  | B. WING           | ·            |   |  | - londonan                 |
|   | ROVIDER OR SUPPLIER ILL NURSING HOME   | INC.  |                   | 58           | EET ADDRESS, CITY, STATE, ZIP CODE<br>37 LYONS VIEW PIKE<br>NOXVILLE, TN 37919  | 1 05   | 5/08/2013                  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG | IX           | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)  | l n oc   | (X5)<br>COMPLETION<br>DATE |
|   | after the 26th to ensure from monitoring.  Interview on May 1, Licensed Practical in hallway confirmed to coccyx area had be order to discontinue were healed had not a second to the coccy. | 2, monitored for one week sure healing, and removed  2013, at 12:30 p.m., with Nurse (LPN) #6 on the 100 he resident's wounds to the en healed, and the physician's ethe catheter when wounds of been followed.                     | F                 | 315          | F 325   |  | 6/21/13                    |
| F 325<br>SS=E   | UNLESS UNAVOID  Based on a resider assessment, the fa resident (1) Maintains accep status, such as bod unless the resident demonstrates that   | of's comprehensive cility must ensure that a cility must ensure that a citable parameters of nutritional ly weight and protein levels, 's clinical condition this is not possible; and apeutic diet when there is a                 | F                 | 325          |   | pased on ment, ent —  f ght and clinical not   |                            |
|   | by: Based on medical facility policy review failed to assess, in interventions, consto maintain accept   | NT is not met as evidenced record review, observation, v, and interview, the facility aplement, monitor, and modify istent with the resident's needs able parameters of nutritional dents (#'s 41, 77, 156, 159, 72) ants reviewed. |                   |              | Resident # 41: No opportunity to coresident moved out of state to be clefamily.  Resident # 77: Residents care plan reviewed by weight loss team members for and updated to reflect we interventions as indicated. Weight members consist of DON, ADON, I | has been<br>bers on<br>eight loss<br>loss team |                            |

## PRINTED: 00/14/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: A, BUILDING \_ AND PLAN OF CORRECTION B. WING 05/08/2013 445114 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5837 LYONS VIEW PIKE BRAKEBILL NURSING HOME INC. KNOXVILLE, TN 37919 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID. (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Medical Records Coordinator, RD, and F 325 F 325 Continued From page 34 MDS Assistant. Referral was also made to RD for review on The findings included: 5/13/2013. Resident #41 was admitted to the facility on Resident # 156: Resident was reviewed by weight November 7, 2012, with diagnoses including loss team members on 5/16/2013. Resident's Dementia, Subdural Hematoma s/p (status post) nutritional concerns will be referred to Fall, Acute Venous Embolism, and Depressive Registered Dietician for evaluation and Disorder.

Medical record review of the Admission Minimum Data Set (MDS) dated November 14, 2012, and the Quarterly MDS dated February 12, 2013. revealed the resident had severe impairment in cognitive skills, and required limited assistance with one person physical assistance for eating.

Medical record review of the physician's recapitulation orders dated April 1, 2013, through April 30, 2013, revealed "...Diet; Regular Chopped Meat, Assist Feeder..."

Medical record review of the Nutrition Risk Assessment dated November 14, 2012, revealed "...Wt (weight) (lb) (pounds) 141.8...IBW (Ideal Body Weight)/Usual 83-101...Overall Risk Category:...(greater or equal) 8 points: High Risk."

Medical record review of the 24 Hour Diet Assessment (undated) revealed "...Adm. (Admission) Date 11-7-12...Feeding Ability: ...Tray Set up Needs Assistance...Diet History: Current Intake: Solid: Good...Fluid:

Good...Nourishments/Supplements: 10:00 AM Choc (chocolate) ice Cream..."

Medical record review of the appetite/supplement form dated 2012-2013 revealed the following weights: November 8, 2012, 141.8 (pounds);

recommendations, but due to resident's decreased lack of accepting intake, continued weight loss is still possible and unavoidable.

Resident # 159: Resident referred to Registered Dietician on 5/16/3012 by weight loss team for nutritional review, recommendations and interventions to address weight loss. Weight loss team members consist of DON, ADON, RNA, Medical Records Coordinator, RD, and MDS Assistant.

Nursing staff will continue to assist resident with all meals x 3 and offer and encourage snacks.

Resident # 72: Resident referred to Registered Dietician by weight loss team on 5/2/3013 for nutritional review, recommendations and interventions to address weight loss. Nursing staff will continue to assist resident with all meals x 3 and offer and encourage snacks

## Identification:

Medical record and weight reviews were used by weight loss team members to identify other residents at risk for weight loss. No other residents were identified. Weight loss team members consist of DON,

| CENTER   | RS FOR MEDICARE  | & MEDICAID SERVICES   |  | _  |  | PPROVED |  |  |  |
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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |   |  | E CONSTRUCTION   | OMB NO. 0938-0391<br>(X3) DATE SURVEY<br>COMPLETED   |         |  |  |  |
|  |  | 445114  | B. WING  |  | 05/05  | 212043  |  |  |  |
| NAME OF PROVIDER OR SUPPLIER BRAKEBILL NURSING HOME INC.                     |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE 5837 LYONS VIEW PIKE KNOXVILLE, TN 37919 |  |  |         |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER CROSS-REFERENCE)   | (X5)<br>COMPLETION<br>DATE   |         |  |  |  |
| F 325  | Medical record revision April 24, 2013, where a series as sessed the residence as a sessed the resident had not assessed the resident had not list for the RD to as Review of the facilit Program, revealed loss will receive a had the medication passed and removed from Program) by an MI will be documented on the Residents on the Nof Nutra-Shake two on the 3-11 shift will come to the die | ew of the Weights New Admit, ation form revealed the weight |  | ADON, RNA, Medical Records Coordinator, RD, and MDS Assistan Measures to be put in place and syst changes:  Weekly weight loss team meetings or of DON, ADON, RNA, Medical Recordinator, RD, and MDS Assistant been initiated on a weekly basis and continue. Residents identified as hav unacceptable weight loss based on w monthly weight review in absence of supporting medical condition will be referred to RD for evaluation and interventions. Director of Nursing/A Director of Nursing will in-service a care staff regarding documentation and nourishment's. Intake percentabe based on and take into account a snack and nourishment intakes, Inswill be conducted by DON/ADON with the period allowed in the 2567 or not than June 22, 2013.  Monitoring of corrective actions:  Residents at risk for significant wei will be reviewed weekly by weight to committee and monitored as an ago as a part of facilities monthly QA/O process beginning 6/1/2013. Weight committee members consisting of I ADON, RNA, Medical Records Coordinator, RD, and MDS Assists | emic  onsisting ords orth orth orth orth orth orth orth ing eekly or  ssistant dil direct of meal ge will ll food, services within olater  ght loss eenm enda item orth orth orth orth orth orth orth orth |         |  |  |  |

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|                          |   | AND HUMAN SERVICES  & MEDICAID SERVICES  |                     |      |  | FORM.     | 09/14/2013<br>APPROVED<br>0938-0391 |
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| TATEMENT                 | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                     |      | ONSTRUCTION  | (X3) DATE | SURVEY<br>PLETED                    |
|                          |   | 445114   | B. WING             |      |  | 05/       | 08/2013                             |
|                          | ROVIDER OR SUPPLIER<br>ILL NURSING HOME   | INC.   |                     | 5837 | TADDRESS, CITY, STATE, ZIP CODE<br>LYONS VIEW PIKE<br>DXVILLE, TN 37919                                    |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | ×    | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | ILD BE    | (X5)<br>COMPLETION<br>DATE          |
| F 325                    | Interview on April 2 Dietary Manager, it the dietary manager resident's signification unaware of any intresident's weight to confirmed," the for about four month interview on April 2 Acting Director of Assistant Director room, confirmed nand weight loss sireview of weight to meetings, no nutri weight loss.  Resident #77 was March 17, 2011, v Failure to Thrive, Congestive Heart Symptoms Concernial Sym | 24, 2013, at 9:00 a.m., with the on the training room, confirmed are was not aware of the ont weight loss, and was erventions in place for the coss. Further interview acility had not had a dietician |                     | 25   | make recommendations and referre   | als to RD |                                     |

Event ID:ECUM11

|                          |   | AND HUMAN SERVICES  & MEDICAID SERVICES  |                   |     |   | FORM     | APPROVED . 0938-0391       |
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| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                   |     | LE CONSTRUCTION   | (X3) DAT | TE SURVEY<br>MPLETED       |
|                          |   | 445114   | B. WING           | ·   |   | 05       | /08/2013                   |
|                          | ROVIDER OR SUPPLIER<br>ILL NURSING HOME   | INC.   | <del>-</del>      | +   | REET ADDRESS, CITY, STATE, ZIP CODE<br>5837 LYONS VIEW PIKE<br>KNOXVILLE, TN 37919                      |          |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAC | ΉX  | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULD BE   | (X5)<br>COMPLETION<br>DATE |
| F 325                    | Continued From page   | age 37   | F                 | 325 | 3   |          |                            |
|                          | following weights:  1. January 25, 201  2. February 26, 20  3. March 21, 2013, 4. April 25, 2013, v loss from the Janu  Review of the physical following:  1. March 26, 2013 times daily due to 2. April 2013 Recaphysician April 23, Salt, Mechanical Shigh Calorie Oran and Nutritional supaday.  3. April 25, 2013, with meals, and w Review of the Merch 2013, a documentation the been administered Medical record re March 15, 2012, s "Potential for ded/t (due to) po (by total feeding with (Encourage)75-10 position for all mewith sip of liquid refused, food pre | weight 79.6#. veight 74# for a 11.8# weight ary 25, 2013 weight. sician orders revealed the Mutritional supplement three weight loss; spitulation Orders signed by the 2013, diet order No Added Soft (texture), Chopped Meat, ge Beverage three times daily oplement 2 ounces three times add buttermilk three times daily eekly weights for four weeks.  dication Administration Record and April 2013, revealed no e nutritional supplement had | i  <br>or         |     |   |          |                            |

snacks and supplements as ordered..." Further

| CENTE                    | RS FOR MEDICARE  | & MEDICAID SERVICES  |                   | MB NO. (     | NO. 0938-0391   |                               |                            |
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|                          | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | ' '               |              | LE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                            |
|                          |  | 445114   | B. WING           | <del>-</del> |   | 05/0                          | 8/2013                     |
|                          | ROVIDER OR SUPPLIER SILL NURSING HOME  | INC.   |                   |              | REET ADDRESS, CITY, STATE, ZIP CODE<br>5837 LYONS VIEW PIKE<br>KNOXVILLE, TN 37919                              | 1 00,0                        | <u> </u>                   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG | ΊX           | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | DBE I                         | (X5)<br>COMPLETION<br>DATE |
| F 325                    | review of the care per the problem or app 2012.  Interview with Certi 2013, at 2:10 p.m., revealed the reside sweet potato, and is nutritional orange seaten in awhile"  Observation on Marevealed the reside the hall and no tray Observation continues identification of the hall and no tray 10% food intake ar Shake (nutritional sounces of ice created of the hall and no tray Observation continuitiensed Practical resident a mixture ounce container of observation revealed the meal.  Interview with the accompany of the meal.  Interview with the accompany of the Mare Mare Mare Mare Mare Mare Mare Mar | plan revealed no changes to roaches since March 15, fied Nurse Aide #8 on April 30, in the resident's room ent had consumed 100% of the buttermilk, 50% of the shake, "best (resident) has by 1, 2013, at 8:31 a.m., and meal delivery cart was on in the resident's room. Sued at 9:21 a.m. revealed the on the over bed table with and 2/3 cup intake of a Mighty supplement) mixed with 4 |                   | 325          |   |                               |                            |

CENTERS FOR MEDICARE & MEDICAID SERVICES

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|   |  | AND HUMAN SERVICES  & MEDICAID SERVICES  |                   |      |   | FORM A                        | 03/14/2013<br>APPROVED<br>0938-0391 |  |
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| TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X1) PROVIDER/SUPPLIER/CLIA  |                   |      | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                                     |  |
|   |  | 445114   | B. WING           |      |   | 05/08/2013                    |                                     |  |
|   | ROVIDER OR SUPPLIER  | INC.   |                   | 58   | EET ADDRESS, CITY, STATE, ZIP CODE<br>37 LYONS VIEW PIKE<br>NOXVILLE, TN 37919                            |                               |                                     |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |      | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY) | D BE                          | (X5)<br>COMPLETION<br>DATE          |  |
| F 325   | 1, 2013, at 8:50 a. confirmed the Mar completed, and " interview with the 2:25 p.m., in the tr weight loss had no plan at the time of and March 2013. nutritional assess addressing the we and March 2013.  Resident #156 w 2012, with diagno Behavioral Disturt Diabetes Mellitus, Epilepsy (history of Anxiety, Gastroes Osteoporosis, He Irritable Bowel Sy Medical record redata set (MDS) direvealed the resident the Brief Interview of the Brief Interview of the March 2013. | 25, 2013.  Registered Nurse #2 on May m., in the training room, ch 2013, MDS was not .Aware care plans behind"  acting DON on May 7, 2013, at aining room, confirmed the ot been addressed on the care the loss in January, February, Further interview confirmed noment was completed eight loss in January, February, was admitted on November 5, see including Dementia with pances, Rheumatoid Arthritis, Coronary Artery Disease, of seizures, recent onset), cophageal Reflux Disease, aring Loss, Hypertension, and |                   | 3325 |   |                               |                                     |  |
|   | revealed the residuant assist of one for bathing.  Review of the so November 11, 20 transferred from   | dent was dependent on staff with eating, personal hygiene, and cial services note dated 012, revealed the resident an assisted living facility to the due to needing more care.  | 1                 |      |   |                               |                                     |  |

|                          |  | AND HUMAN SERVICES  & MEDICAID SERVICES  |                   |          |  | FORM                 | : 05/14/2013<br>APPROVED<br>: 0938-0391 |  |  |
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|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | 1                 | LTIPLE ( | (X3) DA  | TE SURVEY<br>MPLETED |   |  |  |
| _                        | ·  | 445114   | B. WING           | 3        |  | 05                   | /08/2013                                |  |  |
|                          | ROVIDER OR SUPPLIER  | INC.   | <u> </u>          | 5B3      | ET ADDRESS, CITY, STATE, ZIP CODE<br>17 LYONS VIEW PIKE<br>OXVILLE, TN 37919                         |                      | 1 00/00/2010                            |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREI<br>TAG | FIX      | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | QULD BE              | (X5)<br>COMPLETION<br>DATE              |  |  |
| F 325                    | Continued From pa  | age 40   | F                 | 325      |  |                      |   |  |  |
|                          | 6, 2012, revealed,   | sician's order dated November "Please assist with all feeds - tremely limited movement RUE hity)"  |                   |          |  |                      |   |  |  |
|                          | Assessment dated<br>the resident's adm<br>(lbs.), and had bee<br>Risk" for nutritiona<br>hour Diet Assessm | iew of the initial Nutritional Risk November 12, 2012, revealed ission weight was 103 pounds on assessed at being "High I decline. Review of the 24 nent dated November 5, 2012, shments/supplements: 10:00              |                   |          |  |                      |   |  |  |
|                          | from the meal inta<br>weighed 101 lbs. o   | riew of the recorded weights<br>ke log revealed the resident<br>on November 20, 2012, and 95<br>2012, a significant weight loss<br>thirty days.  |                   |          |  |                      |   |  |  |
|                          | 2012, revealed the   | al intake log for November<br>e resident's average intake for<br>%; lunch 54%; and dinner 66%.   | -                 |          |  |                      |   |  |  |
|                          | Albumin level of 3 on January 7, 201   | dent's lab results revealed an .4L (reference range: 3.5 - 5.2) 3, with the physician's signature view on January 8, 2013.   |                   |          |  | ٠                    |   |  |  |
|                          | room on May 1, 2 resident being fed (CNA). Continued resident was alert Continued observ                   | eal service in the resident's 013, at 9:35 a.m., revealed the I by a certified nurse assistant d observation revealed the I, sitting upright in the bed. Vation revealed the resident of bothers of food when offered by |                   |          |  |                      |   |  |  |

| DEPART<br>CENTER         | TMENT OF HEALTH  | AND HUMAN SERVICES  & MEDICAID SERVICES   |                   |     |  | FORM     | : 05/14/2013<br>APPROVED            |
|--------------------------|--|---|-------------------|-----|--|----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                   |     | LE CONSTRUCTION  | (X3) DAT | . 0938-0391<br>TE SURVEY<br>MPLETED |
|                          |  | 445114  | B. WING           | ·   |  |          |                                     |
| NAME OF F                | ROVIDER OR SUPPLIER  | <del></del>   |                   | STE | REET ADDRESS, CITY, STATE, ZIP CODE  |          | /08/2013                            |
| BRAKEE                   | ILL NURSING HOME   |   |                   | 5   | 5837 LYONS VIEW PIKE<br>KNOXVILLE, TN 37919  |          |                                     |
| (X4) ID<br>PREFIX<br>TAG | I (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC (DENTIFYING INFORMATION)  | ID<br>PREF<br>TAG | ΉX  | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRI<br>DEFICIENCY) | II D BE  | (X5)<br>COMPLETION<br>DATE          |
| F 325                    | Continued From pa  | ge 41   | F                 | 325 |  |          |                                     |
|                          | Nurse (LPN) #7 at a half revealed the state residents who need interview confirmed cooperation during sometimes the resisometimes refuses for example resider one bite, which usu  | , 2013, with Licensed Practical 8:05 a.m., on the upper 100 aff assisted with feeding of all ded assistance. Continued at the resident's willingness and feeding varies, stating dent will eat well, and or takes small bites. "Today not would not take medication in tally does. It took three sident to take all the   |                   |     |  |          |                                     |
|                          | (DON) on May 6, 2 hall nurse's station been assessed as lost 8 lbs. during the there was no docur the resident for the interventions were nutrition and preventional interview facility's expectational placed on weekly wand provided nutritional Resident #159 was | acting Director of Nursing 013, at 9:20 a.m., at the 100 confirmed, the resident had high risk on admission; had e 1st month after admission; mentation the facility assessed weight loss; and no implemented to improve nt further weight loss. It with the DON confirmed the n would be that the resident be veights for close monitoring, lonal supplements. |                   |     |  |          |                                     |
|                          | August 17, 2012 w Coumadin (blood ti Congenital Heart N Urinary Tract Infect Congestive Heart I Medical record rev   | ith diagnoses including Chronic hinner medication) for Malfunction, Malaise, Fatigue, tion, Dementia, Depression, Failure and Atrial Fibrillation. Tiew of the admission MDS 2012 revealed the resident   |                   |     |  |          |                                     |
|                          | scored 0/15 on the   | Brief Interview for Mental  |                   |     |  |          |                                     |

|                          |   | AND HUMAN SERVICES  & MEDICAID SERVICES  |                   |     |  | FORM                         | 0: 00/14/2013<br>MAPPROVED<br>0: 0938-0391 |
|--------------------------|---|--|-------------------|-----|--|------------------------------|--|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                   |     | CONSTRUCTION   | (X3) DA                      | TE SURVEY<br>MPLETED                       |
|                          |   | 445114   | 8. WING           | i   |  | 0.                           | 5/08/2013                                  |
|                          | ROVIDER OR SUPPLIER   | INC.   |                   | 583 | ET ADDRESS, CITY, STATE, ZIP CO<br>7 LYONS VIEW PIKE<br>OXVILLE, TN 37919                  |                              |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETION<br>DATE                 |
| F 325                    | required extensive daily living (ADL); a loss.  Medical record rev assessment dated Registered Dieticia received a mechardiet and was totally Medical record rev February 19, 2013 short and long-termoderately impaint totally dependent a significant weight!  Medical record rev revealed the residion October 26, 20 2013-a loss of 21. loss in six months  Medical record rev notes and physicial dated August 17, revealed no weigh implemented.  Review of the fact nourishment docureceived no nutritiaddress the weight. | severe cognitive impairment; assistance with all activities of and had no significant weight liew of the initial nutrition risk. August 21, 2012 by the an revealed the resident nical soft with chopped meat y fed by staff.  Tiew of the quarterly MDS dated revealed the resident had memory problems and ed decision-making skills; was on staff for all ADL; and had no loss.  Tiew of the weight loss record ent weighed 163.2 lbs. (pound) 12 and 141.3 lbs. on April 23, 9 lbs. (13% (percent) weight ).  Tiew of nurses' notes, dietary and's progress notes and orders 2012 through April 24, 2013 and loss interventions had been lility's supplement and umentation revealed the resident ional supplements or snacks to int loss. |                   | 325 |  |                              |  |

|                          |  | AND HUMAN SERVICES  & MEDICAID SERVICES   |                   |              |  |             | APPROVED 0938-0391         |
|--------------------------|--|---|-------------------|--------------|--|-------------|----------------------------|
| TATEMENT                 | ATEMENT OF DEFICIENCIES DE PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445114  AME OF PROVIDER OR SUPPLIER  | (X1) PROVIDER/SUPPLIER/CLIA   |                   |              | PLE CONSTRUCTION   | (X3) DAT    | E SURVEY<br>PLETED         |
|                          |  | 445114  | B. WING           | <del>-</del> |  | 05/         | 08/2013                    |
| NAME OF P                | ROVIDER OR SUPPLIER  |   |                   |              | TREET ADDRESS, CITY, STATE, ZIP CODE<br>5837 LYONS VIEW PIKE   | <del></del> |                            |
| BRAKEB                   | ILL NURSING HOME   | INC.  |                   | ŧ            | KNOXVILLE, TN 37919  |             |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG | XI           | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE        | (XS)<br>COMPLETION<br>DATE |
| F 325                    | Continued From pa  | age 43  | F                 | 32           | 5  |             |                            |
|                          | p.m. with the contr<br>RD had not assess<br>and the resident ha  | w on April 24, 2013 at 3:15<br>acted RD confirmed the new<br>sed the resident's weight loss,<br>ad not been placed on the<br>RD to assess related to weight   |                   |              |  |             |                            |
|                          | and interview on A training room with and the acting Ass confirmed the resing Continued interview assessed the resident assessed the resident assessed the continued interview assessed the resident asset as a resident asset as a resident asset as a resident as a re | riew of the weight loss record pril 24, 2013 at 4:25 p.m. in the the acting Director of Nursing sistant Director of Nursing dent had a weight loss. We confirmed a RD had not dent since August 21, 2012, and ad been put in place to prevent loss. | 3                 |              |  |             |                            |
|                          | revealed the resid   | oril 30, 2013, at 7:55 a.m.,<br>lent sitting up in bed being fed a<br>panana, corn flakes with whole<br>ry juice by Restorative CNA#1.  |                   |              |  |             |                            |
|                          | December 10, 20  | s admitted to the facility on<br>12, with diagnoses including<br>ase, Encephalopathy, and<br>c Condition.   |                   |              |  |             |                            |
|                          | (MDS) dated Dec<br>resident had seve<br>and required exte  | eview of the Minimum Data Set<br>sember 17, 2012, revealed the<br>ere impairment in cognitive skills<br>ensive assistance with one<br>assistance for eating.  | 5,                |              |  |             |                            |
|                          | 2013, revealed the impairment in co  | eview of the MDS dated March one resident had severe gnitive skills, and was totally one person physical assistance   | 9,                |              |  |             |                            |

| CENTE                    | RS FOR MEDICARE  | & MEDICAID SERVICES  |                      |               |   |  | APPROVED  |
|--------------------------|--|--|----------------------|---------------|---|--|---|
| STATEMENT                | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MUI<br>A. BUILD | LTIPL<br>DING | E CONSTRUCTION  | OMB NO. 0938-0391<br>(X3) DATE SURVEY<br>COMPLETED |   |
|                          |  | 445114   | B. WING              |               | ·   |  | 2010010   |
| NAME OF F                | PROVIDER OR SUPPLIER   |  |                      | STR           | EET ADDRESS, CITY, STATE, ZIP CODE  | 1 05/0   | 08/2013   |
| BRAKEE                   | BILL NURSING HOME  | INC.   |                      | 58            | 337 LYONS VIEW PIKE<br>NOXVILLE, TN 37919   |  |   |
| (X4) ID<br>PREFIX<br>TAG | I (EACH DEPICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>. PREFI<br>TAG | x             | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED OF THE | nes l  | (X5)<br>COMPLETION<br>DATE                        |
| F 325                    | for eating.  | -  | F3                   | 325           |   |  | <del>, , , , , , , , , , , , , , , , , , , </del> |
|                          | Assessment dated<br>"Wt (weight) (lb) (                                      | ew of the Nutrition Risk<br>December 17, 2012, revealed,<br>(pounds) 157}BW (Ideal<br>Il 90-110Diet order<br>k Category: High" |                      |               |   |  |   |
|                          | resident weighed a   | ew of the appetite/supplement per 2012/2013, revealed the 148.5 pounds in February, 138.9 pounds in March, 2013. Tone month)   |                      |               |   |  |   |
|                          | Medical record revi<br>dated January 20, 2<br>to mechanical soft of          | ew of a Physician's Order<br>2013, revealed "Upgrade diet<br>chopped meat"   |                      |               |   |  |   |
|                          | Summary dated Fe   | ew of a Monthly Nursing<br>bruary 5, 2013, revealed<br>al feeder (with) poor intake"   |                      |               |   |  |   |
|                          | Review of the nouri revealed the reside a.m.                                 | ishment sheet (undated)<br>nt received pudding at 10:00  |                      |               |   |  |   |
|                          | Review of the Resident does n  | dent Supplement List revealed ot receive a supplement.   |                      |               |   |  |   |
|                          | revealed the reside<br>by CNA #4, a chop                                     | ril 30, 2013, at 8:10 a.m.,<br>ant sitting up in bed being fed<br>ped muffin, scrambled eggs,<br>at and cranberry juice.       |                      |               | ·   |  |   |
|                          | training room, with  | 4, 2013, at 2:30 p.m., in the the acting Assistant Director of the resident had a weight                                       |                      |               |   |  | i   |
| ORM CMS-25               | 567(02-99) Previous Varsions   |  |                      |               |   | <del></del>  |   |

|   |   | AND HUMAN SERVICES  & MEDICAID SERVICES  |                   |      | . ,   |                               | APPROVED<br>0938-0391      |
|---|---|--|-------------------|------|---|-------------------------------|----------------------------|
| TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                   |      | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                            |
|   |   | 445114   | B, WING           | ·    |   | <br>  05/0                    | 8/2013                     |
|   | ROVIDER OR SUPPLIER<br>LL NURSING HOME  | INC,   | _                 | 5    | REET ADDRESS, CITY, STATE, ZIP CODE<br>B37 LYONS VIEW PIKE<br>(NOXVILLE, TN 37919                               |                               |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAC | :IX  | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE                          | (X5)<br>COMPLETION<br>DATE |
|   | assessed the resid admission in Decel Interview on April 3 training room, with (DON), confirmed on January 30, 20 first visit to the faci and the contracted week.  Interview on April 3 Restorative CNA # confirmed they obliook at the weights interview confirme weight loss in a macontinued interview eight loss in a macontinued interview confirmed the 6.7% 2013 to March 20 Interview on May 1 training room, with nourishments on 1 on a separate tray the intake of the 1 resident had not by intake form.  Interview on May Certified Nursing confirmed the resident had resident had not by intake form. | tered Dietician (RD) had not ent since the resident's mber 2012.  10, 2013, at 9:15 a.m., in the the acting Director of Nursing the full time RD was terminated 13, and the contracted RD's lity was on March 26, 2013, RD was here for 6 hours per 130, 2013, at 3:15 p.m. with 14 and #2, in the training room, rain the resident's weights, and 15 from month to month. Further 16 if there is a 5% or greater onth they will inform dietary. We confirmed they would have weight loss from February 13 on Resident #72 to dietary.  12, 2013, at 8:50 a.m., in the 16 the acting DON, confirmed the 16 the nourishment sheets come of from dietary, and confirmed 0:00 a.m. pudding for the 16 the deen documented on the meal 17, 2013, at 10:30 a.m., with Assistant (CNA) #5, in the hall, ident ate 100% of the pudding. |                   | 325  |   |                               |                            |
| F 356<br>SS=C   |   | ED NURSE STAFFING  |                   | F 35 | 56  |                               |                            |

| CENTE         | RS FOR MEDICARE   | & MEDICAID SERVICES   |                     |             |  | FORM      | M APPROVED                 |
|---------------|---|---|---------------------|-------------|--|-----------|----------------------------|
| STATEMENT     | OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:         | (X2) MU<br>A. BUILI | JLYI<br>DIN | IPLE CONSTRUCTION  | (X3) DA   | 0. 0938-0391<br>TE SURVEY  |
| <u>-</u>      |   | 445114  | B. WINC             | G _         |  | 0.6       | 510012043                  |
| NAME OF F     | ROVIDER OR SUPPLIER   |   |                     | s           | STREET ADDRESS, CITY, STATE, ZIP CODE  | 1 05      | 5/08/2013                  |
| BRAKER        | BILL NURSING HOME   | INC   |                     |             | 5837 LYONS VIEW PIKE   |           | ]                          |
|               |   |   |                     | l           | KNOXVILLE, TN 37919  |           | ł                          |
| (X4) ID       | SUMMARY STA   | TEMENT OF DEFICIENCIES  | ID.                 |             | · <del></del>  |           |                            |
| PRÉFIX<br>TAG | I (EACH DEFICIENCY  | MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)       | PREF<br>TAG         | FΙΧ         | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | III D BE  | (X5)<br>COMPLETION<br>DATE |
| F 356         | The facility must po  | ge 46<br>st the following information on                      | F                   | 35          | 56 F 356   |           | 6/21/13                    |
|               | a daily basis:  |   | 1                   |             | Brakebill Nursing and Rehabilita   | . +! a.u  |                            |
|               | o Facility name.  |   | 1                   |             | Center supports the posting of th  | o ouncier | 1                          |
|               | o The current date.   | and the actual hours worked                                   |                     |             | staffing data on a daily basis at the  | e untenta |                            |
|               | by the following cafe   | egories of licensed and                                       |                     |             | beginning of each shift.   |           |                            |
|               | unlicensed nursing<br>resident care per sh  | staff directly responsible for<br>ift:                        |                     |             | Corrective Action:   |           |                            |
|               | - Registered nui<br>- Licensed pract<br>vocational nurses (a<br>- Certified nurse | tical nurses or licensed<br>as defined under State jaw).      | I                   |             | Nursing staffing data has been   |           |                            |
|               | o Resident census.  |   |                     |             | on a daily basis at the beginning  |           |                            |
|               | <u> </u>  |   | !                   |             | each shift listing the current da  |           |                            |
|               | specified above on<br>of each shift. Data<br>o Clear and readab                   |   |                     |             | total number and actual hours by nursing staff positions as rec  |           |                            |
|               | o In a prominent pla<br>residents and visito                                      | ace readily accessible to rs.                                 |                     |             | Identification;  |           |                            |
|               | 1   |   |                     |             | No resident care issues are ide  |           |                            |
|               | The facility must, up   | oon oral or written request,                                  |                     |             | as being adversely affected by t   | he lack   | }                          |
|               | make nurse staffing<br>for review at a cost<br>standard.                          | data available to the public not to exceed the community      |                     |             | of posting of daily nursing staff period of April 26 ~ 29, 2013.                                       | for the   |                            |
|               |   |   |                     |             | Measures to be put in place and  |           |                            |
|               | staffing data for a n   | aintain the posted daily nurse<br>ninimum of 18 months, or as |                     |             | systemic changes:  | ı         |                            |
|               | required by State la  | w, whichever is greater.                                      | 1                   |             | Director of  |           |                            |
|               |   |   |                     |             | Nursing/Assistant Director of i  | lursing   |                            |
|               | This RECTUDE MEN  | NT is not met as evidenced                                    |                     |             | will in- service all unit manage   |           |                            |
|               | by:   | vi is not met as evidenced                                    |                     |             | and/or shift supervisors regard  | -         |                            |
|               | , -   | tion and interview the facility                               |                     |             | requirement of posting direct c  |           |                            |
|               | failed to post accur  | ate nurse staffing information                                |                     |             | nursing hours provided on each   |           |                            |
|               | from April 26 through   | ah April 29, 2013.  |                     |             | In-services will be conducted w  |           |                            |
|               | The findings includ   |   |                     |             | the period allowed in the 2567 later than June 22, 2013.   | or no     |                            |
| OPM CMS 1     | 1<br>2567/02-99) Provious Version   |   | <u> </u>            |             |  |           |                            |

PERMITTED THE RECEDIAN FINISHED SERVICES

| CENTERS FOR MEDICARE   |  |                     |   | RM APPROVED<br>VO. 0938-0391 |
|--|--|---------------------|---|------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | CONSTRUCTION (X3)   | DATE SURVEY<br>COMPLETED     |
|  | 445114   | B. WING             |   | 0510010040                   |
| NAME OF PROVIDER OR SUPPLIER   | <u> </u>   | STRE                | EET ADDRESS, CITY, STATE, ZIP CODE  | 05/08/2013                   |
| BRAKEBILL NURSING HOME   | INC.   | 58                  | 37 LYONS VIEW PIKE<br>NOXVILLE, TN 37919  |                              |
| PREFIX (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)  | (X5)<br>COMPLETION<br>DATE   |
| F 356 Continued From pa  | nge 47   | F 356               | Monitoring of corrective actions:   |                              |
| the main entrance nurse staffing information Friday, April 26, 20  Interview with the at (aDON), at the time the staffing information and the current posmot been updated of 483.35(i) FOOD PISTORE/PREPARE  The facility must - (1) Procure food from the considered satisfact authorities; and | acting Director of Nursing e of the observation, confirmed ation should be updated daily, sting was inaccurate and had or accurate for three days. ROCURE, //SERVE - SANITARY  om sources approved or ctory by Federal, State or local distribute and serve food | F 371               | Visual observations will be utilized to confirm posting of nursing staff requirements each morning for the previous day and current day posting by the DON/ADON and/or shift supervisor. Non-compliance will be reported to manager in charge for correction.  F 371  Brakebill Nursing and Rehabilitation Center ensures that facility must procure food from sources approved or considere satisfactory by Federal, State or local authorities; and should store, prepare, distribute and serve food under sanitary conditions. | 6/21/13                      |
| by: Based on observation of the findings included to the serve food failed to maintain the sanitary manner. The findings included the servation on App.m., of the 300 has taking trays off the   | NT is not met as evidenced ation and interview, the facility of in a sanitary manner; and the dietary department in a ded:  oril 29, 2013, beginning at 12:20 all revealed two nursing staff a resident tray delivery cart and fire length of the hall passing   |                     | Corrective Action:  Dictary Trays: All food item are covered with an approved, well-fitting lid. Desser were immediately covered by a saran wr film upon distribution from the dictary department.  Plastic Bowls: Storage procedure was immediately changed to ensure open end bowls do not come in contact with the tra   | ts<br>ap<br>of               |
| ORM CMS-2567(02-99) Previous Version   |  | V11 F-              | cility ID: TN4702 If continuation   | sheel Page 48 of             |

SELECTIONERAL OF DEVELOPMEND HOMINIA SEKAICES

|   |  | AND HUMAN SERVICES  & MEDICAID SERVICES  |                   |              |  | FORM /  | APPROVED                   |
|---|--|--|-------------------|--------------|--|---|----------------------------|
| TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |  |                   | CONSTRUCTION | OMB NO. 0938-0391<br>(X3) DATE SURVEY<br>COMPLETED   |   |                            |
|   |  | 445114   | B. WING           | ·            |  | 05/0  | 08/2013                    |
|   | OVIDER OR SUPPLIER<br>LL NURSING HOME  | INC.   |                   | 583          | ET ADDRESS, CITY, STATE, ZIP CODE<br>37 LYONS VIEW PIKE<br>NOXVILLE, TN 37919  | 1 05/   |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG | ıx           | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE | D BE  | (X5)<br>COMPLETION<br>DATE |
|   | and other residents observation revealed were not wrapped.  Interview with Certiff and April 29, 201 Hallway, confirmed entire length of the interview with CNA p.m., in the 300 Haresident's meal tray with desserts on the wrapped, " normation them"  Observation on Ap 2:55 p.m., in the diand interview with Registered Dietitia observations, confunctions of the bow 2. A dietary staff mapkins that were 3. The can opener blade, base and sliblack sticky debris 4. The floor mixer | tion carts, housekeeping carts, it, visitors and staff. Further and the desserts on the trays fied Nursing Assistant (CNA) 3, at 12:27 p.m., in the 300 walking a resident's tray the hall with unwrapped desserts.  #2 on April 29, 2013, at 12:31 at |                   | 371          | Silverware and Napkins: Dietary stamembers instructed by dietary man same day as discovered, on proper procedure of rolling silverware and ensure silverware is dry and napking.  Can Opener: Opener was immediate cleaned by dietary manager to accessanitary standards.  Floor mixer: Underside of the beate was immediately cleaned by dietary manager to acceptable standards.  Identification:  No identifiable residents could be determined as being affected by connoted.  Measures to be put in place and systemic changes:  Dietary manager immediately held service to communicate to dietary stresults of noted inspection and initiate corrective measures. Cleaning schedupdated to include inspection and emeasures to be taken.  Monitoring of corrective measures initiated by visual observations by distinctions of corrective measures initiated by visual observations by dietary measures.   | ager, on to s clean. ely ptable, ar arm ditions ditions an in- laff ated lule was orrective |                            |
| F 373<br>SS=E   | 483.35(h) FEEDIN<br>TRAINING/SUPE  | IG ASST -<br>RVISION/RESIDENT  | F                 | 373          | manager shift supervisor(s) and/or   | lead<br>monitor   |                            |

|  |   | AND HUMAN SERVICES & MEDICAID SERVICES   |                   |                          | FORM   | APPROVED . 0938-0391       |  |  |
|--|---|--|-------------------|--------------------------|--|----------------------------|--|--|
| TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA |   |  |                   | LE CONSTRUCTION (X3) DAT | E SURVEY<br>MPLETED  |                            |  |  |
|  | 445114  |  | B. WING           | _                        | 05.  | 05/08/2013                 |  |  |
|  | ROVIDER OR SUPPLIER<br>ILL NURSING HOME   | INC,   |                   |                          | REET ADDRESS, CITY, STATE, ZIP CODE<br>5837 LYONS VIEW PIKE<br>KNOXVILLE, TN 37919   |                            |  |  |
| (X4) ID<br>PREFIX<br>TAG                             | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |                          | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  | (XS)<br>COMPLETION<br>DATE |  |  |
|  | A facility may use a defined in §488.30 assistant has succe State-approved trairequirements of §4 residents; and the consistent with State A feeding assistant            | paid feeding assistant, as for this chapter, if the feeding essfully completed a ining course that meets the 83.160 before feeding use of feeding assistants is te law.  must work under the gistered nurse (RN) or licensed   |                   |                          | compliance observations to dictary manager. Sanitation inspection observations will be reviewed as an agenda item monthly during monthly QA/QI meeting beginning 6/1/2013  F 373  Brakebill Nursing and Rehabilitation Center will ensure that facility training for | 6/21/13                    |  |  |
|  | supervisory nurse system.  A facility must ensified only resident feeding problems.  Complicated feeding not limited to, difficaspirations, and tuto the facility must be | a feeding assistant must call a for help on the resident call ure that a feeding assistant ts who have no complicated and problems include, but are culty swallowing, recurrent lung the or parenteral/IV feedings. The resident seessment and the resident's it and plan of care. |                   |                          |  |                            | feeding assistants meets State approved requirements.  Corrective Action:  State approved feeding assistant training has been identified and will be ordered. Feeding assistants will receive new State approved training as identified by Program Manager before being allowed to assist with feeding.  Identification: |  |
|  | regulatory require feeding assistants program with the specified at §483, o A State-approve   | ed training course for paid<br>s must include, at a minimum, 8<br>n the following:   |                   |                          | Two feeding assistants were identified for revised training as a feeding assistant.  Measures to be put in place and systemic changes:  The State approved training course as identified will be ordered and utilized for current and future feeding                 |                            |  |  |

| CENTE                    | INEIVI OF HEALIH<br>RS FOR MEDICARE   | AND HUMAN SERVICES  & MEDICAID SERVICES  |                                       |     |   | FORM   | 7: U5/14/2013<br>MAPPROVED                         |  |
|--------------------------|---|--|---------------------------------------|-----|---|--|--|--|
| STATEMEN                 | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                                       |     | PLE CONSTRUCTION  | (X3) DA  | OMB NO. 0938-0391<br>(X3) DATE SURVEY<br>COMPLETED |  |
|                          |   | 445114   | B. WING                               | s   |   |  | 100/0040   |  |
|                          | ROVIDER OR SUPPLIER BILL NURSING HOME   | INC.   | · · · · · · · · · · · · · · · · · · · |     | REET ADDRESS, CITY, STATE, ZIP CODE<br>5837 LYONS VIEW PIKE<br>KNOXVILLE, TN 37919  |  | /08/2013   |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG                     | ix  | PROVIDER'S PLAN OF CORE<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY)   | HOULD BE   | (X5)<br>COMPLETION<br>DATE                         |  |
| F 373                    | Assistance with feeding and hydration. Communication and interpersonal skills. Appropriate responses to resident behavior. Safety and emergency procedures, including the Heimlich maneuver. Infection control. Resident rights. Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse.  A facility must maintain a record of all individuals used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants. |  | F                                     | 373 | assistants. Requirements for the program will be followed and documented for each assistant a participates in the program. Tr will be conducted by appropriaticensed personnel. Feeding assintilized until State approval is a program and staff receives appropriational appropriation of corrective action.  Compliance and passage of appropriation be documented and reviewed by Nursing as evidence of completimade a part of employee's educible for inspection and review. | who aining te stants will not btained for roved training. s: roved training y the Director ion. Results wi | will<br>of<br>H be                                 |  |
|                          | by: Based on observat feeding assistant co interview the facility State-approved train paid feeding assista The findings include Observation on May 300 Hall, revealed a at resident #187's b mechanically altere Interview with the fe the observation, rev completed feeding  | ning program for two of two ants. ed: 75, 2013 at 12:40 p.m., on the paid feeding assistant sitting edside, feeding the resident a |                                       |     |   |  |  |  |

|   |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                   |              | ł   | יוואז (אואז): ו<br>FORM A | J5/14/2013<br>PPROVED      |
|---|--|---|-------------------|--------------|---|---------------------------|----------------------------|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IN TABLED. |  |   |                   | CONSTRUCTION | OMB NO. 0938-0391<br>(X3) DATE SURVEY<br>COMPLETED  |                           |                            |
|   |  | 445114  | B. WING           | i            |   | 0.5101                    |                            |
|   | ROVIDER OR SUPPLIER ILL NURSING HOME   | INC.  | <u> </u>          | 5B3          | ET ADDRESS, CITY, STATE, ZIP CODE<br>7 LYONS VIEW PIKE<br>OXVILLE, TN 37919   | <u>  05/08</u>            | 3/2013                     |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC !DENTIFYING INFORMATION)  | ID<br>PREF<br>TAG | ıx           | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED (DEFICIENCY)              | DBF 1                     | (X5)<br>COMPLETION<br>DATE |
| F 373   | A copy of the trainir feeding assistants, February 2013, was The Program Mana credentialling was compared assistant program. Interview with the a (aDON) and acting (aADON) on May 6 300 hall nursing statemploys two staff in of assisting dependence of assistant program. Interview with the analysis of assisting dependence of assisting dependence of a State-approved The DON and ADC the curriculum was and they verbalized interview, that no face of the compared to the curriculum was and they verbalized interview, that no face of the curriculum was and they verbalized interview, that no face of the curriculum was and they verbalized interview, that no face of the curriculum was and they verbalized interview, that no face of the curriculum was and they verbalized interview, that no face of the curriculum was and they verbalized interview, that no face of the curriculum was and they verbalized interview, that no face of the curriculum was and they verbalized interview, that no face of the curriculum was and they verbalized interview. | nts work on one of four halls at meal coverage  ag curriculum for the two paid trained in the facility, in a requested and reviewed.  ager (PM) for State course contacted by email, on May 6, and the PM verified the facility e-approved paid feeding  cting Director of Nursing Assistant Director of Nursing, 2013, at 1:05 p.m., at the ation, confirmed the facility nembers for the sole purpose lent residents with meals. The ents completed in-house of 2013, but the curriculum was ed feeding assistant course. N stated they were unaware not a State-approved course, I understanding during the acility staff could assist with thout having completed a | F                 | 373          |   |                           |                            |
| F 505<br>SS=D   | 483.75(j)(2)(ji) PR(<br>OF LAB RESULTS   | OMPTLY NOTIFY PHYSICIAN   | F                 | 505          | F 50 <b>€</b>   |                           | 6/21/13                    |
|   | The facility must pr<br>physician of the fin   | romptly notify the attending dings.   |                   |              | Brakebill Nursing and Rehabilitati<br>Center supports the requirement to<br>physician be promptly notified of largestits. | hat a                     |                            |
|   | This REQUIREME   | NT is not met as evidenced  |                   |              | results.  |                           |                            |

|   |   | AND HUMAN SERVICES  & MEDICAID SERVICES   |                   |     |  | FORM  | US/14/2013<br>APPROVED     |  |
|---|---|---|-------------------|-----|--|---|----------------------------|--|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA |   | (X2) MULTIPLE CONSTRUCTION A. BUILDING  |                   |     | (X3) DAT   | OMB NO. 0938-0391<br>(X3) DATE SURVEY<br>COMPLETED  |                            |  |
|   |   | 445114  | B. WING           |     |  | 05/   | 05/08/2013                 |  |
|   | ROVIDER OR SUPPLIER   | INC.  |                   | 583 | ET ADDRESS, CITY, STATE, ZIP CODE<br>37 LYONS VIEW PIKE<br>IOXVILLE, TN 37919  | 1 00  | 00/2010                    |  |
| (X4) ID<br>PREFIX<br>TAG                              | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG | ×   | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY)  | DULD BE   | (X5)<br>COMPLETION<br>DATE |  |
| F 505   | the facility failed to of lab results for on residents reviewed. The findings includ. Resident #78 was a 22, 2012 with diagr. Epilepsy, Depression Psychosis.  Medical record revidated April 1, 2013 count)/B12 (vitamin (prealbumin)/Dilantievel/Depakote (med-2-13"  Medical record review from pharm4-10-13depak but not in the chart Medical record review from pharm need Depakote and Medical record review with the (DON) on May 1, 2 Hall nurse station, | record review and interview, promptly notify the physician re resident (#78) of sixty-four ed:  admitted to the facility on June noses including Dementia, on, Dysphagia, and Affective liew revealed a physician order "CBC (complete blood in B 12)/Folate/PAB tin (anti-seizure medication) cod stabilizer) level on liew of medication regimen racy revealed, ote and Dilantin level ordered t"  Tiew of medication regimen racy revealed, "4-30-13still and Dilantin level"  Triew revealed no lab results for one were in the chart.  Triew revealed no lab results for one were in the chart.  Triew of medication regimen racy revealed no lab results for one were in the chart. | F                 | 505 | Corrective Action:  Resident # 78: No opportunity to dates for lab results for this residents were obtained on May I physician was notified of resultatime.  Identification:  Upon record review by unit secret resident as was identified as havilab results.  Measures to be put in place and changes:  Nursing Director/Assistant Directory will inservice all unit sunit managers and/or shift supergarding the requirement of recorders for acquisition of resident note in lab log when results are Unit secretaries will report receives to licensed staff member physician notification.  Inservices will be conducted with period allowed in the 2567 or not June 22, 2013. | ident. Lab , 2013 and s at that  etaries, no oth ng outstandir systemic ctor of necretaries, rvisors viewing all t labs and to obtained. ipt of lab for |                            |  |
|   | resident's chart. (   | ote were present in the<br>Continued interview with the<br>, confirmed the lab results were   |                   |     | Monitoring of corrective acti  | 00\$:   | 1                          |  |

| UEPAK I<br>CENTER   | MENT OF HEALTH   | AND HUMAN SERVICES  & MEDICAID SERVICES   |                              | FORM.  | 05/14/2013<br>APPROVED        |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445114 |  | (X1) PROVIDER/SUPPLIER/CLIA   | (X2) MULTIPLI<br>A. BUILDING | E CONSTRUCTION (X3) DATE   | 0938-0391<br>SURVEY<br>PLETED |
|   |  | 445114  | B. WING                      |  | 00/0040                       |
|   | ROVIDER OR SUPPLIER<br>ILL NURSING HOME  | INC.  | 58                           | REET ADDRESS, CITY, STATE, ZIP CODE<br>837 LYONS VIEW PIKE<br>NOXVILLE, TN 37919   | 08/2013                       |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG          | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  | (X5)<br>COMPLETION<br>DATE    |
| F 505   | physician until May  | ge 53<br>facility or reviewed by the<br>1, 2013, and confirmed a<br>fication of physician of lab                                      | F 505                        | Unit managers and/or shift supervisor notify shift supervisor of any outstanding lab results pending which will be communicated to relieving supervisor for follow-up and physician notification. Unit secretaries and/or unit manager will review lab logs each shift and will notify   |                               |
| F 514<br>SS=D   | The facility must ma resident in accordary standards and practically document systematically orga. The clinical record information to identify assessm services provided; the preadmission screen and progress notes. This REQUIREMENT.  | must contain sufficient ify the resident; a record of the ents; the plan of care and the results of any ening conducted by the State: | F 514                        | DON/ADON and/or supervisor of any results still pending after 24 hours unless lab has been flagged as a stat result. Compliance will be reported monthly by DON/ADON during QA/QI Meeting beginning 6/1/2013.  F 514  Brakebill Nursing and Rehabilitation Center supports the requirement that a facility must maintain clinical records on each resident in accordance with acceptable professional standards and practices.  Corrective Action: | 6/21/13                       |
|   | by: Based on medical record review and interview, the facility failed to maintain a complete medical record for one (#77) resident of sixty-four reviewed.  The findings included: Resident #77 was admitted to the facility on March 17, 2011, with diagnoses including Adult Failure to Thrive, Alzheimer's Disease, Dementia, |   |                              | Resident # 77: Laboratory services provider contacted by unit secretary to resend lab result for the dates indicated to be filed in residents chart.  Identification:  Record review indicated no other resident record.   |                               |
|   | Congestive Heart F   | Failure, and Atrial Fibrillation.   |                              | did not contain laboratory studies as ordered.   |                               |

|   |  | AND HUMAN SERVICES  & MEDICAID SERVICES  |                   |              |  | FORM   | APPROVED . 0938-0391       |
|---|--|--|-------------------|--------------|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |  |                   | CONSTRUCTION | (X3) DAT   | (X3) DATE SURVEY<br>COMPLETED                      |                            |
| <u></u>   | 445114   |  | B. WING           | ·            |  | 05   | /08/2013                   |
|   | ROVIDER OR SUPPLIER  |  |                   | 58           | EET ADDRESS, CITY, STATE, ZIP CODE<br>37 LYONS VIEW PIKE<br>NOXVILLE, TN 37819   | 1 00,  | 0012010                    |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |              | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)   | LD BE  | (X5)<br>COMPLETION<br>DATE |
| F 514   | Medical record revi<br>revealed laboratory<br>laboratory results w<br>19, 2013, and April<br>Interview with the D<br>Medical Record Dir<br>4:12 p.m., in the tra<br>medical record faile | ew of physician phone orders studies were ordered and vere to be obtained on March | F                 | 514          | Measures to be put in place and syste changes:  Unit secretaries and/or unit manager review lab logs each shift and will no DON/ADON and/or supervisor of an results still pending after 24 hours unlab has been flagged as a stat result, secretary will assume responsibility filing lab results in the medical reconfollowing physician notification by in nursing staff. Procedure will be communicated to nursing staff through in-service conducted by DON/ADON services will be conducted within the allowed in the 2567 or no later than 2013. Compliance will be reported in by DON/ADON during QA/QI Mee beginning 6/1/2013. | will dify ly nless Unit for d censed Igh an N. In- |                            |